Personalized Recovery Oriented Services (PROS)

Program & Operations Manual

2025

Effective 04/01/2025

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USE OF THIS MANUAL

This Program and Operations Manual is intended to clearly describe the model, outline program requirements, share best practices, and provide operational guidance to PROS programs. In addition to this manual, administrators and staff should familiarize themselves with 14 NYCRR 512, the PROS Standards of Care (SOC), and the PROS Billing & Claiming Manual.

Note that this manual has been issued in advance of CMS approval of the proposed State Plan Amendment (23-0098) and is subject to change.

This manual includes a number of best practices and recommendations, which are identified using the below icons:

This ribbon icon indicates a best practice for consideration.

This exclamation icon indicates an OMH recommendation.

If you have any questions regarding this PROS Program and Operations Manual, please contact your local OMH Field Office PROS Liaison or the Rehabilitation and Treatment Services Unit at OMH Central Office.

PART 1: PROGRAM OVERVIEW

INTRODUCTION

Personalized Recovery Oriented Services (PROS) is a comprehensive team-based, site-based program model that integrates rehabilitation, treatment, and support services for adults (18+) with serious mental illness. The program is a flexible, person-centered, recovery-oriented program that serves a diverse population and fosters a supportive community.

Individuals who are engaged in the program work towards achieving meaningful goals in different areas of their lives, for example:

- Living independently
- Building natural supports and personally meaningful relationships
- Finding and keeping a job
- Reaching higher levels of education
- Securing preferred housing
- Improving whole health and wellness

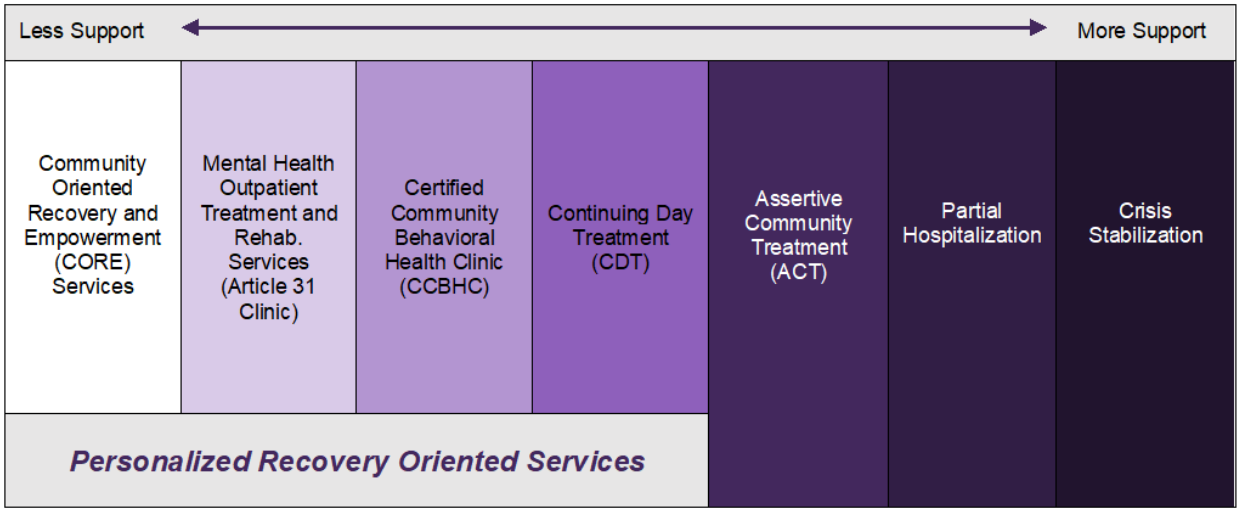
The PROS model is based on a strong community of participants at all stages of recovery. Programs "meet people where they're at," engaging participants in services both within the program space and natural environments where they live, work, learn, and socialize. Services are offered in-person and through telehealth, individually and in groups. While at the program, participants socialize and engage in recovery-oriented activities that support skill development. All PROS services are directed by a person-centered planning process, where medically necessary services are selected to address the participant's mental health barriers to recovery goals. The frequency, intensity, and duration of services is based on the participant's needs and preferences.

There are four components in PROS: Community Rehabilitation and Support (CRS), Intensive Rehabilitation (IR), Ongoing Rehabilitation and Support (ORS), and Clinical Treatment (CT). PROS programs may be licensed at PROS with Clinical Treatment or PROS without Clinical Treatment. All PROS programs strive to deliver integrated rehabilitation and treatment services. When a participant receives outside clinical treatment services, PROS programs work closely with their outside providers to ensure that participant's needs are met.

PROS IN THE PUBLIC MENTAL HEALTH CONTINUUM OF CARE

The PROS model is designed to allow for a high degree of flexibility and creativity to meet the needs of each program's local community. PROS staff and participants have shared that this is a unique strength and characteristic that fosters a diverse community where participants feel welcomed, empowered, and supported at all stages of recovery.

Figure 1 New York State Adult Outpatient Mental Health Continuum of Care



The above visual is intended to illustrate how PROS fits in the continuum of care, acting as both a step up and step down from other levels of service based on the frequency and intensity of an individual's participation in the program.

Note: This chart is *not* intended to describe co-enrollment allowances (commonly referred to as allowable service combinations). For more information on co-enrollment, please see the PROS Billing & Claiming Manual.

KEY PRINCIPLES AND VALUES

PROS programs operate on a set of shared key principles and values that guide services, policies, and procedures:

1. Programs facilitate ***shared decision making (SDM)*** in all aspects of service planning and delivery. According to Substance Abuse and Mental Health Services Administration (SAMHSA), SDM "aims to help people in treatment and recovery have informed, meaningful, and collaborative discussions with providers about their health care services" (2022). Programs offer objective information through conversations, tools, and resources, ensuring that participants are involved in every aspect of service planning and decision making. Services are driven by a person-centered Individualized Recovery Plan (IRP).

2. The model is rooted in ***recovery***. Recovery-oriented services promote hope and encourage each participant to establish their own path towards recovery. PROS programs operate on the belief that all individuals have the capacity for recovery from mental illness and addiction. Formal and informal peer support are embedded in the model to support the recovery orientation.

3. PROS programs create an ***intentional community*** where participants at all stages of life and recovery support each other. PROS programs offer the opportunity for participants to engage in a recovery-oriented environment in the shared community space. Participants are empowered to contribute through leading recovery-oriented activities and clubs, participation in an advisory board, and community meetings. Participants build comradery, engage in peer support, celebrate each other's successes, and practice skills in a safe space.

4. PROS programs deliver ***team-based***, ***integrated*** rehabilitation, treatment, and supported employment and education services. All multidisciplinary team members work collaboratively to ensure that services are coordinated and aligned with each participant's recovery goals and objectives. This ensures that participants build unique connections with multiple staff members and benefit from working with staff from different disciplines, perspectives, and backgrounds. Peer Specialists are equal members of the PROS team.

5. PROS programs employ the use of multiple ***evidence-based practices*** (EBP) throughout individual and group services. This includes several essential EBPs such as Integrated Treatment for Co-Occurring Disorders, Individual and Family Psychoeducation, Individual Placement and Support (IPS), and Wellness Self-Management (WSM). Programs may also incorporate additional EBPs based on practitioner skills and training including but not limited to Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy, Dialectical Behavior Therapy (DBT), Solution Focused Therapy (SFT), Motivational Interviewing, etc.

6. The PROS Team demonstrates ***cultural sensitivity and humility*** throughout engagement, assessment, recovery planning, and service delivery. Services should consider how sociodemographic, racial, and ethnic populations differ, as well as how ethnic, cultural, social, environmental, religious, and historical factors might influence specific beliefs and behaviors.

7. Services are inclusive of the participant's ***social network*** in the recovery process. With consent, family of choice and other natural supports may be included throughout the recovery planning and service delivery process. Programs support participants with building and strengthening social networks, recognizing that informal supports are key to recovery and sustaining valued life roles.

8. Programs recognize the importance and value of economic self-sufficiency and the impact of poverty on mental health. Programs will reinforce the belief that participants can be productive contributors who add value to the workforce and society. Programs will encourage ***economic empowerment***, supporting participants in cultivating opportunities for increased income, resources, and independence that align with personally meaningful goals.

9. PROS programs work with participants in pursuing ***active participation and membership*** in the communities of their choice. Programs facilitate meaningful engagement in the community, supporting participants in making positive contributions in the communities and settings where they live, work, learn, and socialize.

10. PROS programs recognize that physical and mental health are inextricably linked and offer services and activities that support participants with ***achieving wellness***. SAMHSA defines eight Dimensions of Wellness: Emotional, Physical, Occupational, Social, Spiritual, Intellectual, Environmental, and Financial (SAMHSA, 2016). PROS supports participants in overcoming mental health barriers to achieve whole health and wellness.

Figure 2 Key Values & Principles of the PROS Model

PART 2: ELIGIBILITY

ELIGIBILITY CRITERIA

To be eligible for admission to a PROS program, an individual must:

- Be 18 years of age or older,
- Have a designated mental illness diagnosis,
- Have a functional disability due to the severity and duration of mental illness, and
- Be recommended for admission by a Licensed Practitioner of the Healing Arts (LPHA).

DESIGNATED MENTAL ILLNESS DIAGNOSIS

A *designated mental illness diagnosis* is a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis or International Classification of Diseases (ICD) equivalent other than:

- substance-related and addictive disorders in the absence of other mental health conditions defined in the DSM or ICD,
- neurodevelopmental disorders in the absence of other mental health conditions defined in the DSM or ICD, except Attention-Deficit/Hyperactivity Disorder and Tic Disorders,
- neurocognitive disorders, including traumatic brain injury, or mental disorders due to another medical condition,[1] or
- V-Codes. Other conditions that may be a focus of clinical attention (commonly described with Z codes).

Note: A diagnosed designated mental health disorder diagnosis is required for admission; however, “unspecific mental disorder” (F99) may be used to support billing/claiming for pre-admission screening services.

FUNCTIONAL DISABILITY

A *functional disability* is a deficit caused by the designated mental illness that rises to the level of impairment in one or more major life activities, such as:

- Activities of daily living (ADLs): eating, dressing, bathing, grooming, etc.
- Instrumental activities of daily living (IADLS): managing finance, cooking and meal preparation, managing medications, attending appointments, navigating community, etc. and,
- Participating in family, school, or workplace: establishing and maintaining positive interpersonal relationships and interactions, managing mental health symptoms in different environments or settings, emotional regulation, self-advocacy, etc.

[1] Individuals with such neurodevelopmental or neurocognitive disorders may be eligible to receive PROS if they also have a qualifying mental health diagnosis and related functional deficit. These individuals must demonstrate a cognitive ability to participate in and benefit from PROS, as assessed by an LPHA.

LPHA RECOMMENDATION

The LPHA recommendation documents medical necessity for PROS.

The practitioner completing the recommendation should consider factors including, but not limited to, the individual's diagnosis and functional impairment, their preferences and choice to enroll in PROS, reason for seeking services/support, mental health status, their cognitive ability to engage in PROS, and whether they are likely to benefit from PROS.

Clinical Discretion in Making a Recommendation

LPHAs have a responsibility to fully consider whether PROS is the appropriate level of service for any given individual. There will be some individuals who meet the age, diagnosis, and functional disability criteria for admission to PROS, but who may not *benefit* from PROS at this point in their recovery process and should not be recommended for admission (e.g., individuals who are only interested in psychotherapy or clinical treatment services).

While PROS can support individuals with goals related to socializing and personal relationships, it *is not* a socialization program and may not be an appropriate fit for individuals who are satisfied in their life circumstances and are only seeking a long-term socialization setting. Individuals with co-occurring mental illnesses and intellectual/developmental disabilities or neurocognitive disorders *may* be eligible for admission to PROS, if the LPHA determines that the individual has a functional disability caused by the mental illness that can be addressed through PROS. PROS programs cannot address or treat barriers or challenges caused by intellectual/developmental disabilities and neurocognitive disorders.

ABILITY TO PAY

It is important to note that insurance status and ability to pay may not be considered when making a recommendation for admission. PROS programs receive net deficit funding (state aid) to help offset the cost of serving participants without Medicaid. Programs must offer individuals without Medicaid a sliding fee scale (see PROS Billing & Claiming Manual for more information).

NON-DISCRIMINATION

Programs must adhere to State and Federal laws regarding non-discrimination. Programs may not exclude individuals due to history of substance use, incarcerations, Assisted Outpatient Treatment (AOT) status, or multiple serious mental illness diagnoses.

PART 3: COMPONENTS & SERVICES

COMMUNITY REHABILITATION & SUPPORT (CRS)

COMPONENT DEFINITION

The CRS component is used to engage and assist participants at any stage in their recovery journey with managing their mental health symptoms. CRS services involve partnering with the participant to develop and/or restore the skills and supports necessary for them to live as independently as possible in the community of their choice. The CRS component may also be used as an intervention to stabilize various situations of acute stress, partner with the participant to identify solutions and facilitate connections to relevant supports and community resources.

The CRS component includes the following services:

- Pre-Admission Screening
- Alcohol, Tobacco, and Other Drug Assessment
- Complex Care Management
- Crisis Intervention
- Individualized Recovery Planning
- Peer Support Services (optional)
- Psychiatric Rehabilitation Assessment
- Psychosocial Rehabilitation

SERVICE DEFINITIONS & GUIDANCE

Pre-Admission Screening

Service Definition

Pre-admission Screening includes engaging, interviewing, and evaluating an individual to determine whether they are appropriate for the program and identifying and addressing any unique circumstances and functional limitations which may impact their ability and desire to receive PROS services.

Staff Qualifications

Pre-Admission Screening is conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff.

Guidance

This service may be used by the program's LPHA to screen for eligibility and to complete the LPHA recommendation when appropriate.

For more information on pre-admission and documentation requirements related to this service, please see the Pre-Admission, Intake, and Assessment section of this manual.

Alcohol, Tobacco, and Other Drug Assessment

Service Definition

Alcohol, Tobacco, and Other Drug Assessment is designed to gather data concerning a participant's substance-related history and current use and assess such data to determine their substance use status, the need for substance use services or referral.

Staff Qualifications

Professional Staff

Guidance

It is important to note that PROS employs a harm reduction approach to substance use and other risky behaviors. This approach involves perceiving substance use and other risky behaviors on a continuum, allowing for gradual and incremental changes that promote risk reduction tailored to a participant's specific goals and motivations.

For more information on documentation requirements related to this assessment, please see the Assessment section of this manual.

Psychiatric Rehabilitation Assessment

Service Definition

Psychiatric Rehabilitation Assessment is an assessment of the participant's strengths and barriers encountered as a result of their psychiatric condition and identifies life role goals to be addressed in the IRP. This assessment service is always completed with active involvement of the participant.

Qualified Staff

Psychiatric Rehabilitation Assessment is conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff.

Guidance

This assessment is part of the psychiatric rehabilitation process and focuses on partnering with the participant to determine the living, learning, working, and social roles they wish to achieve. The PROS practitioner should explore culturally relevant themes to further understand the participant and identify any cultural strengths and challenges. Such themes may include, but are not limited to, the participant’s beliefs about mental illness and recovery, cultural identity, gender identity, nationality, native language, racial and ethnic identity, religious and spiritual beliefs, self-perceptions, sexual orientation, social identity, and socioeconomic status.

The Psychiatric Rehabilitation Assessment service is used not only for the initial Comprehensive Psychiatric Rehabilitation Assessment, but also in support of the psychiatric rehabilitation process throughout the participant’s engagement in PROS. This service may be used to:

- Assess the participant’s readiness to participate in psychiatric rehabilitation services;

- Explore their personal beliefs in the possibility, positivity, and manageability of change, coupled with an understanding of change-related knowledge;
- Identify characteristics the participant wants to have in their ideal role or setting;
- Examine previous experiences and recognize future preferences related to settings and roles;
- Describe alternative options;
- Specify possible options for a satisfying role and what each entail;
- Research various available options;
- Identify the critical skills needed to attain the life goal;
- Identify critical supports needed to attain the life goal; and
- Assess skill performance or access to a support in various settings.

PROS staff who have received training through the New York Psychiatric Rehabilitation Training Academy may employ various readiness assessment tools using this service.

For more information on documentation requirements related to the comprehensive psychiatric rehabilitation assessment, please see the Assessment section of this manual.

Individualized Recovery Planning

Service Definition

Individualized Recovery Planning is a continuous, dynamic process that engages each participant as an active partner in developing, reviewing, and modifying an Individualized Recovery Plan (IRP) that supports their progress towards recovery. The IRP is based on an assessment process and the participant's personal preferences and desired recovery goals.

Qualified Staff

Individualized Recovery Planning is conducted by Professional Staff or Paraprofessional Staff under the supervision of an LPHA.

Guidance

As a participant engages in the psychiatric rehabilitation process, this service may be used to facilitate the goal setting and planning process. Staff will support the participant with crafting a goal statement, revising their IRP to reflect the skills and supports needed to attain their goal, and regularly assessing their progress in acquiring skills or accessing resources and supports.

Examples of Individualized Recovery Planning include but are not limited to:

- Exploring and refining a participant’s PROS goal as they explore various roles and environments,
- Meeting with the participant to collaboratively write their monthly summary note, reviewing together the progress they have made and any significant events that should be noted,
- Collaboratively reviewing and updating the participant’s IRP based on the current goals, objectives, needs, and preferences; and

- Working with the participant to identify any collaterals or family of choice they would like included in their PROS services.

Complex Care Management (CCM)

Service Definition

Complex Care Management services are time-limited, non-routine care coordination and skill building services which are necessary to restore functioning and address the symptoms of mental illness. This service includes helping the participant to connect with medical or remedial services in response to an urgent need. CCM may involve communication with collaterals and family of choice for the direct benefit of the participant. This service also includes skill-building to help the participant identify solutions to problems that threaten their recovery and community tenure.

Qualified Staff

Complex Care Management is conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff.

Guidance

CCM is a *non-routine* rehabilitative service designed to coordinate care due to an urgent need that could impact the participant's status or functioning in the community if left unaddressed. CCM may be provided with or without the participant present and often includes communication with family of choice and other collaterals identified by the participant, including other service providers. CCM is not intended to be provided as a stand-alone service; it is typically provided subsequent to another PROS service during which the need for CCM is identified. There is typically a sense of urgency when the need for CCM is identified, and it should be provided as quickly as possible to preserve the participant's status in the community and functioning in life roles. Very often, this service will be provided in conjunction with IR – Intensive Relapse Prevention.

Due to the urgent and non-routine nature of CCM, it is typically not included on a participant's IRP prior to service delivery. Documentation of CCM services must demonstrate the need or rationale for providing the service, clearly indicating the intended impact of the service as it relates to the participant's mental health status and/or functioning in the community.

The need for CCM can be driven by a variety of situations. Examples of such situations include but are not limited to:

- Complex health status:
    - The PROS psychiatric provider or nurse collaborating with a Primary Care Provider or other medical specialist regarding increased physical health symptoms for a participant with comorbid medical conditions.
- Changes in custody status of children/dependents:

    - The PROS practitioner collaborates with Child Protective Services (CPS), school officials, and other providers involved with the participant's family to prevent out-of-home placements for the participant's children/dependents.
- Loss of community status:
    - The PROS practitioner attends AOT related meetings and court appearances as it relates to the participant's mandated services in PROS.
- Loss of employment, income, or benefits:
    - The Employment Specialist works closely with ACCES-VR to coordinate supports/resources needed to sustain employment.
- Loss of home:
    - The PROS practitioner communicates with the participant's landlord to prevent eviction and negotiate a plan of action to address concerns that are threatening housing status.

CCM *does not include required and routine paperwork or follow up*, such as writing letters to obtain benefits/entitlements, activities related to a practitioner's role as a mandated reporter, and time spent documenting services provided. Completing SPOA or housing applications with and on behalf of a participant *may* be billable as CCM *if* there is an immediate threat to their housing status that requires urgent intervention by the PROS practitioner.

Staff may employ *skill building* through CCM to teach problem-solving and system navigation skills, supporting participants through paperwork and application processes that they complete on their own behalf. For example, if a participant receives a notice that they have not submitted their wages to the Social Security Administration and they may lose their Social Security benefits if they do not submit necessary documentation, the Employment Specialist could use CCM to teach the participant how to quickly report their wages online, navigating the process with the participant to ensure deadlines are met and paperwork is submitted appropriately. This example illustrates CCM because of the urgency and time sensitivity of the need and the risk of harm to the participant. If the participant is likely to need additional skill building to continue wage reporting, the program could add a PSR service focused on benefits and financial management to their IRP, ensuring that the Employment Specialist or other qualified staff are available to provide instruction and support on an ongoing basis.

Crisis Intervention

Service Definition

Crisis Intervention is designed to safely and respectfully de-escalate situations of acute distress or agitation which require immediate attention.

Qualified Staff

Crisis Intervention is conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff.

Guidance

A crisis is an unplanned event that requires a rapid response. As such, this service is not typically included on a participant's IRP. Documentation of Crisis Intervention services should provide clear justification for the medical necessity of the service.

Crisis Intervention in PROS is typically a brief intervention to address a specific situation. An example of Crisis Intervention in PROS would be using calming techniques to interrupt escalating behavior. If a participant is requiring Crisis Intervention at a high frequency or intensity, the PROS team and participant should consider adding Intensive Rehabilitation – Intensive Relapse Prevention to their IRP.

Peer Support Services (PSS)

Service Definition

Peer Support Services includes psychoeducation, person-centered goal planning, demonstrating effective coping skills, and facilitating community connections and crisis support to reduce symptomology and restore functionality. PSS promote recovery, self-advocacy, and the development of natural supports and community living skills. Individuals actively participate in decision-making and the delivery of services. Services are directed toward achievement of the participant's goals, as documented in their IRP.

Qualified Staff

Peer Support Services are conducted by New York Certified Peer Specialists (NYCPS), including provisionally certified peers (NYCPS-P), or credentialed Youth Peer Advocates (YPA), including provisionally credentialed YPAs, under the supervision of competent mental health professionals. Note that YPAs who are not also NYCPS or NYCPS-P may only deliver PROS Peer Support Services to participants ages 18-26.[2]

When not supervised by a certified or credentialed peer staff, it is strongly recommended that the supervisor complete peer supervision trainings as described in the PROS Staff Training & Competencies Guidance.

Guidance

Peer Support Services are always provided through the lens of shared lived experience. It is a service intended to promote socialization, recovery, wellness, self-advocacy, development of natural supports, and development and growth of community living skills. Peer Support Services

[2] YPAs who do not hold a NYCPS or NYCPS-P may only deliver PROS Peer Support Services to participants ages 18-26, however a streamlined cross-credentialing pathway is available for all YPAs to become dually certified. For more information, please see the New York Peer Specialist Certification Board website.

may also be used to strengthen and enhance a participant's commitment to their established goal(s) that support their own recovery through engagement in PROS.

Peer Support Services include but are not limited to:

- *Self-Advocacy, Self-Efficacy, and Self-Direction:* Promoting self-directed recovery by exploring individual purpose beyond the identified mental illness, building self-advocacy skills, and raising awareness of existing social support and services. Examples of advocacy support include:
    - Coaching and demonstrating shared decision-making and skills that support collaboration, in addition to providing opportunities to self-advocate,
    - Demonstrating strengths-based interactions by accentuating the positive and highlighting the participant's strengths that can be used to address barriers to recovery,
    - Supporting participants to become empowered to express their dreams, strengths, and assets that encourage self-direction and choice,
    - Exploring the fears, expectations, and anxieties to promote positive and effective communication,
    - Assisting the participant to frame questions to ask providers,
    - Assisting with the development of psychiatric advance directives and wellness action plans (relapse prevention plans),
    - Working alongside the participant as they navigate benefits and entitlements, including food, shelter, and permanent housing,
    - Connecting participants to warmlines and peer-run groups in the community (in-person and online),
    - Using lived experience to support the participant's self-advocacy prior to and during appointments with providers outside of PROS and during visits to the emergency department, when directed or requested by the participant,[3] and
    - Providing hope and encouragement around community inclusion and participation.
- *Empowerment:* Supporting participants to make positive changes and achieve their goal(s). Empowerment emphasizes hope and wellness through the intentional sharing of personal lived experience as it pertains to the situation and need. Examples of empowerment include:
    - Validating the participant's experiences and feelings and conveying hope to the participant about their own recovery,
    - Relating their own recovery stories and sharing and describing personal recovery practices, and helping the participant to discover recovery practices that will work for them,
    - Demonstrating a recovery lifestyle, including participating in recovery activities that might be beyond the scope of non-peer staff, and

[3] In this example, the Peer Worker is not meant to simply accompany the participant to appointments, but will share their lived experience to build self-advocacy skills, coaching and role playing conversations with providers, and support the participant in navigating complex systems to create opportunities for shared decision making and informed consent.

    - Discussing and sharing ongoing personal efforts to enhance health, wellness, and recovery.
- *Bridging and Transitional Support:* Supporting a participant with long or repeated hospitalizations, detox admissions, or other institutional stays as they transition back to their home and community. This may also include support for a participant who is moving from a higher level of residential services to a lower level of residential or housing support. Examples of bridging and transitional support include:
    - Providing support to a participant with aftercare providers upon discharge from emergency rooms, detox units, inpatient psychiatric units, etc.,
    - Serving as a bridge between a participant and their other service providers, supporting a productive and respectful partnership while ensuring the participant is connected to the correct staff responsible for a warm hand-off, and
    - Advising and mentoring participants in self-advocacy activities related to follow up with providers Bridging and Transitional Support also includes supporting the participant with connecting to their community and/or family of choice. It can include "bridging" from structured services like PROS to communities of the participant's choosing.

The Peer Support Service in PROS is an *optional service* at this time. Programs may provide this service if they have qualified staff to do so. Because PSS in PROS is focused on achievement of the PROS goal in the participant's IRP, there may be times when a participant to also receives peer support services in another program. When it is found that a participant is engaged in peer services at another program (e.g., CORE Services or MHOTRS), the PROS program must collaborate with the other provider to ensure coordination between the programs. For more information on allowable service combinations, please refer to the PROS Billing & Claiming Manual.

Certified Peers *are not limited* to only providing Peer Support Services. They may deliver any service they are qualified to deliver as a paraprofessional or professional staff, depending on their qualifications and supervision.

There may be instances where a specific intervention could be categorized as Peer Support Services *or* another PROS service (e.g., Psychosocial Rehabilitation). When determining what type of service is being provided, programs and staff should consider several factors beyond the specific qualifications of the staff who delivered the service, including but not limited to:

- Has the participant expressed a preference for receiving this specific intervention or support through Peer Support vs. another approach (e.g., therapy or psychosocial rehabilitation)?
- Was the service delivered through the lens of shared lived experience?
- How is the service or intervention identified on their IRP?

Psychosocial Rehabilitation (PSR)

Service Definition

Psychosocial Rehabilitation is a skills training and psychoeducation service designed to assist the participant to overcome mental health barriers that may have interfered with their ability to function independently and perform normative adult roles in settings where they live, work, learn, and socialize. Rehabilitation counseling, skill building, and psychoeducational interventions are used to support the attainment of person-centered recovery goals and valued life roles and restore the participant's functional level to the fullest possible and promote independence and full community participation.

Staff Qualifications

Psychosocial Rehabilitation is conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff.

Guidance

PSR is a broad service that incorporates several interventions and modalities, including but not limited to:

- Basic Living Skills Training (BLST)
- Benefits and Financial Management (BFM)
- Community Living Exploration (CLE)
- Engagement in Recovery
- Skill Building for Self-Help (SBSH)
- Structured Skill Development and Support (SSDS)
- Wellness Self-Management (WSM)

For more information on what each of these may entail, see Appendix C.

PSR may be used to support participants with researching and exploring their ideal roles and settings (environments) as part of the psychiatric rehabilitation process. PSR is the foundation for supporting participants in building critical skills and accessing supports needed to be successful with their chosen role and in their chosen environment.

INTENSIVE REHABILITATION (IR)

COMPONENT DEFINITION

The IR component is used to intensively assist participants in attaining specific life roles such as those related to competitive employment, independent housing, and school. The IR component may also be used to provide targeted interventions to reduce the risk of hospitalization or relapse, loss of housing, or involvement with the criminal justice system, and to help participants manage their symptoms.

The IR component includes the following services:

- Cognitive Remediation
- Family Psychoeducation/Intensive Family Support
- Goal Acquisition
- Relapse Prevention
- Integrated Treatment for Co-Occurring Disorders

IR services are eligible for an add-on rate when billing requirements are met. See the PROS Billing & Claiming Manual and the Telehealth Services Guidance for additional details. It is noted that any restrictions on billing for the IR component should not impact or limit the ability of a participant to receive IR if it is medically necessary.

SERVICE DEFINITIONS & GUIDANCE

Cognitive Remediation

Service Definition

Cognitive Remediation is a set of techniques and interventions, such as drills, activities, and exercises, designed to improve a participant's functioning by improving the cognitive skill that is the target of the remediation task. These skills include but are not limited to the ability to pay attention, remember, process information, solve problems, organize and reorganize information, and communicate and act upon information. Cognitive Remediation techniques work to improve mental capabilities necessary to learn academic subject matter, and more generally to function in daily life.

Staff Qualifications

Cognitive Remediation is conducted by Professional Staff or Paraprofessional staff under the supervision of Professional Staff, who have received training approved by OMH.

Guidance

Cognitive Remediation is a behavioral treatment for people who are experiencing cognitive impairments that interfere with daily functioning (Medalia, Revheim, & Herlands, 2009, p. 1).

Cognitive Remediation in PROS is meant to improve functioning through the use of repetitive exercises, typically done via specialized computer software or online programs. It is an approach that has been found to be particularly effective in treating the cognitive impairments associated with schizophrenia spectrum disorders. The cognitive skills addressed through Cognitive Remediation should reflect the participant's recovery and service goals. PROS staff should support participants with transferring skills learned through cognitive remediation into their home and community.

Cognitive Remediation is *not* appropriate for addressing impairment associated with intellectual disabilities.

Cognitive Remediation is an optional PROS service, subject to prior review and written approval by OMH through an Administrative Action process. For more information, please see Part 13 of this manual.

Family Psychoeducation/ Intensive Family Support

Service Definition

Family Psychoeducation (FPE)/Intensive Family Support is designed to provide information, guidance, and support to the participant and their family of choice, for the purpose of assisting and enhancing the capacity of the family member, friend, or significant other to reduce a participant's symptomatology, restore functioning, and facilitate their overall recovery.

Staff Qualifications

Family Psychoeducation is conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff who have completed required trainings as outlined in the PROS Staff Training & Competencies Guidance.

Guidance

Family Psychoeducation is an approach for partnering with participants and families to treat serious mental illnesses. Trained PROS staff will develop a working alliance with the participant and their family of choice (collaterals). In family therapy, the family itself is the object of treatment. However, in the FPE approach, the PROS staff, participant, and their family of choice work together to support the participant's recovery.

Family of choice may include people who live with or provide non-paid support to a participant, such as friends, roommates, significant others, peers, clergy, as well as parents, siblings, spouses, children, other relatives, foster family, etc. or anyone defined by the participant as family. Note: Family does *not* include other paid service providers such as housing/ residential staff or care coordinators.

With the participant's informed consent, this service may be delivered to the family of choice without the participant present. As collaterals, family members must be identified in the case record, and approved by the participant, as having a role in supporting the participant's recovery and goals.

Programs may wish to explore extended hours (evenings, weekends) to allow for identified collaterals to participate in supporting the participant's recovery.

Goal Acquisition

Service Definition

Goal Acquisition is designed to assist a participant in attaining and retaining personally meaningful goals that will help the person to resume normal functioning in adult life roles. This service should be used to provide active support once a participant has made a commitment to achieving a new role, such as returning to work or school, returning to adult care giving or parenting roles, resuming roles as a spouse or significant other, obtaining a desired housing arrangement, and resuming a role as a community volunteer.

Staff Qualifications

Goal Acquisition is conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff.

Guidance

Goal Acquisition is intended to provide time-limited, active support to a participant in order to attain their goal. Services should be focused on skill and resource development, skill programming, and other interventions necessary to address related barriers. Due to the urgency associated with the participant's readiness to attain and maintain a preferred life role, this service is not normally a long-term intervention.

If appropriate, Goal Acquisition may be done in a group setting, but is more likely beneficial when this service is often provided 1:1, as interventions should be tailored to specific goals and barriers. Given the intensive nature of this service, it should be delivered at the frequency needed to support the rapid attainment of the new life role.

The Goal Acquisition service may be needed in the days, weeks, and months leading up to a significant change for the participant; examples include but are not limited to:

- Applying for or beginning a new educational program,
- Moving to a new apartment or residential setting,
- Applying for jobs, starting a new job, or changing positions at work,
- Starting a new relationship or joining a new social group,
- Quitting tobacco or beginning a weight loss program, or
- Regaining custody of their children.

In these instances, PROS staff should be reinforcing the skills learned in PROS, assisting the participant with accessing and refining necessary supports, and problem-solving to address any new or urgent barriers that may arise.

Both the Goal Acquisition service and Relapse Prevention (below) include interventions intended to *maintain* or *sustain* someone in a life role or environment. When selecting the appropriate service, Goal Acquisition would be more appropriate to intensively support someone

in a newly acquired or resumed life role, to assist them with maintaining progress. Intensive Relapse Prevention would be more appropriate to intensively support someone whose life role or functioning is threatened by an immediate risk, typically related to an exacerbation of behavioral health symptoms or relapse.

Relapse Prevention

Service Definition

Relapse Prevention is designed to address an exacerbation of acute symptoms or manage existing symptoms that are not responsive to the current service formulation. This may include the provision of targeted, intensive interventions necessary to address immediate risks such as relapse, hospitalization, loss of housing, or involvement with the criminal justice system or in using other methods to either minimize their symptoms or permit the participant to continue to work towards their recovery notwithstanding their symptomatology. This service may also include the execution of a series of predetermined steps identified in the personal wellness plan, relapse prevention plan, or advance directive.

Staff Qualifications

Relapse Prevention is conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff.

Guidance

Relapse Prevention is a short-term, intensive intervention designed to provide active support to a participant who is at risk of relapse or the loss of a chosen life role.

Often programs may find that this service needs to be provided individually, as interventions should be tailored to the participant's specific circumstances and environment.

Examples of when this service may be needed include but are not limited to:

- Following an arrest or mobile crisis call,
- Following discharge from a psychiatric or substance use-related hospitalization or emergency room visit,
- If Child Protective Services has been contacted about concerns with a participant's parenting,
- If Adult Protective Services has been contacted about a participant's ability to care for themselves,
- Receipt of an eviction notice or warning from a landlord,
- A written warning from the participant's employer,
- Academic probation or a failing grade in school,
- Uncharacteristic changes in medication adherence or substance use, or
- A recognized pattern of exacerbated symptoms that have previously led to negative consequences.

Integrated Treatment for Co-Occurring Disorders

Service Definition

Integrated Treatment for Co-Occurring Disorders is a rehabilitation counseling service based on evidence-based practices that include motivational, cognitive-behavioral and harm reduction techniques designed to restore functionality and promote recovery for participants with both mental health and substance use disorders. This specialty service is integrated as the focus is to overcome barriers and impairments caused by both mental health and substance use disorders.

Staff Qualification

Integrated Treatment for Co-Occurring Disorders is conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff who have completed required trainings as outlined in the PROS Staff Training & Competencies Guidance.

Guidance

A core principle of Integrated Treatment for Co-Occurring Disorders[4] is the use of trained staff to treat both disorders simultaneously using stage-wise interventions, including motivational interviewing and cognitive behavioral approaches.

Long-term substance use recovery requires comprehensive, coordinated, consistent, competent, and compassionate treatments; as such, this service is not time limited.

PROS programs large enough to sustain group-based services should include multiple options such as persuasion, active treatment, and relapse prevention groups:

- Persuasion groups would be beneficial for participants in the contemplation and preparation stages of change. These motivational and educational groups are intended to teach participants about addiction and recovery, support participants with understanding the pros and cons of change, developing discrepancies between their substance use and goal(s), and recognizing their own strengths and successes.
- Active treatment groups are appropriate for participants in the action stage of change. These groups will focus on skill development for managing co-occurring disorders, facilitation of positive peer support, and cognitive behavioral interventions.
- Relapse prevention groups are appropriate for participants in the maintenance stage of change. These groups will focus on relapse prevention planning, establishing supports to maintain lifestyle changes, positive peer support, and building on supportive clinical relationships.

[4] This approach is often referred to as “integrated treatment for dual disorders” or “integrated dual disorder treatment.”

Tobacco (Nicotine) Use Disorder is considered a co-occurring disorder, and treatment should be integrated throughout the services the program offers, including Integrated Treatment for Co-Occurring Disorders. The PROS model is well suited to provide Tobacco Dependence Treatment (TDT), as staff receive training in addiction and behavioral change strategies. The frequency and intensity of contact offered by this service allows for increased monitoring of nicotine withdrawal, exacerbation of mental health symptoms, and side effects due to cessation-induced increases in medication levels.

ONGOING REHABILITATION AND SUPPORT (ORS)

COMPONENT DEFINITION

The ORS component is designed to assist participants in managing symptoms and overcoming functional impairments as they integrate into a competitive workplace or integrated educational or training program. ORS interventions shall focus on supporting participants in maintaining competitive integrated employment or completing an educational or training program.

The ORS component includes a single service by the same name.

ORS services are eligible for an add-on rate when billing requirements are met. See the PROS Billing & Claiming Manual for additional details. It is noted that any restrictions on billing for the ORS component should not impact or limit the ability of a participant to receive ORS if it is medically necessary.

SERVICE DEFINITION & GUIDANCE

Ongoing Rehabilitation and Support (ORS)

Service Definition

ORS services are psychosocial rehabilitation services including rehabilitation counseling, social, coping, and basic living skills training services designed to assist a participant manage the disabling symptoms of mental illness in the workplace or in an educational program, develop strategies for resolving issues in the workplace and school or training program, and maintain other functional skills necessary to sustain competitive employment or to complete an educational program. These services are customized to the participant and necessary to help the participant achieve a rehabilitation goal defined in their individualized recovery plan. ORS is provided to participants who are working in integrated employment settings or participating in integrated educational programs. ORS does not include tutoring, educational, vocational or job training services.

Staff Qualifications

Ongoing Rehabilitation and Support is conducted by Professional Staff or Paraprofessional Staff under the supervision of Professional Staff

Guidance

ORS may only be provided to a participant who is employed in a competitive, integrated job or who are enrolled in a formal, integrated educational program. For the purposes of determining ORS eligibility, participants who are engaging in gig work are considered to meet this requirement, if such work earns income reported on in an IRS Form 1099 (e.g., Uber Eats, Task Rabbit, Instacart).

Formal, integrated educational programs include but are not limited to enrollment in an apprenticeship or vocational training program, literacy educational program, adult education program (e.g., BOCES), and college or university. Participants do not need to be enrolled in a degree seeking program to receive ORS, but participation in the educational program must relate to their PROS goal.

ORS may not be provided to support an individual's participation in an OMH-funded employment or education service (e.g., Transitional Employment Program, Clubhouse/ Psychosocial Club).

PROS providers and participants have reported concerns regarding the discomfort some participants experience when receiving services in public. The PROS model supports employment and education related goals for participants in *all* PROS service components. If a participant expresses a strong preference for receiving employment- or education-related services on-site, the program may deliver such services through CRS and IR.

ORS aligns with the Individual Placement and Support (IPS) principle of time-unlimited follow-along supports for participants who are working or participating in an educational program. As such, ORS will often continue for a period *after* a participant has been discharged from other PROS components.

In the context of an educational goal, ORS may include but is not limited to skill building related to requesting and using reasonable accommodations (self-advocacy), study skills, accessing resources on campus, navigating financial aid and scholarships, and social skills necessary for success in the classroom.

CLINICAL TREATMENT (CT)

COMPONENT DEFINITION

The Clinical Treatment component is designed to help participants achieve and maintain recovery from mental health conditions by treating the symptoms of those conditions and restoring skills which have been lost due to the onset of mental illness and which are necessary for participants to manage and cope with the symptoms and behaviors associated with mental health conditions and function successfully in the community. PROS with Clinical Treatment must have a staffing plan which includes sufficient qualified staff to deliver clinical treatment services and additional space to perform clinical treatment services.

The CT component includes the following services:

- Clinical Counseling and Therapy
- Medication Management
- Psychiatric Assessment
- Health Assessment
- Symptom Monitoring

SERVICE DEFINITIONS & GUIDANCE

Clinical Counseling and Therapy (CCT)

Service Definition

Clinical Counseling and Therapy is designed to provide goal-oriented verbal counseling or therapy for the purpose of addressing the emotional, cognitive and behavioral symptoms of a mental health disorder. CCT is also intended for engaging, motivating and stabilizing persons with a co-occurring mental health and addiction disorders, and the related effects on role functioning. CCT includes including but not limited to individual, group and family counseling or therapy.

Qualified Staff

Clinical Counseling and Therapy is conducted by Professional staff (excluding Certified Psychiatric Rehabilitation Practitioners, Pastoral Counselors, Therapeutic Recreation Specialists, and Rehabilitation Counselors) and Paraprofessional staff, including Student Interns, where appropriate under state scope of practice laws, under the supervision of Professional staff, except Certified Psychiatric Rehabilitation Practitioners, Pastoral Counselors, Therapeutic Recreation Specialists, and Rehabilitation Counselors.

Guidance

CCT complements the rehabilitative services offered under the CRS, IR, and ORS components. For example, if a participant has been working with the rehabilitation staff to develop, generalize

or strengthen a skill, but they struggle to implement the skill in real life due to persistent mental health symptoms, the qualified staff delivering CCT might address the mental health barriers through therapy and counseling. This requires a high level of integration and communication.

When family counseling is provided, it must be clearly established that the focus of the service is on the PROS participant and their recovery.

Medication Management

Service Definition

Medication Management is designed to prescribe or administer medication to treat the primary symptoms of a participant's psychiatric condition. This service is intended to include medication trials which are adequate in dose and duration, as well as assessment of the appropriateness of the participant's existing medication regimen through record reviews, ongoing monitoring, and consultation with the PROS participant and/or collateral. Medication Management may include monitoring the side effects of prescribed medications including, but not limited to, extrapyramidal, cardiac and metabolic side effects, and may include providing participants with information concerning the effects, benefits, risks and possible side effects of a proposed course of medication.

Staff Qualifications

Medication Management is conducted by a psychiatrist or a nurse practitioner in psychiatry.

Registered professional nurses, and licensed practical nurses under the supervision of a registered professional nurse, licensed physician, or physician assistant, may also administer medication.

Guidance

Any participant who receives Medication Management through PROS must be seen by the psychiatrist or nurse practitioner in psychiatry at least once every 3 months.

The Medication Management services is used to determine personal preferences, as well as past and present experiences with medication, including related efficacy, side effects and compliance. The psychiatrist and/or nurse practitioner in psychiatry is strongly encouraged to employ a shared decision-making approach to medication management. For more information, please see *Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions* (SAMHSA, 2011).

PROS programs are strongly encouraged to offer pharmacological treatment of addiction disorders, including tobacco use disorder, alcohol use disorder, and opioid use disorder for individuals with co-occurring conditions. This includes FDA-approved medications such as varenicline or nicotine replacement therapy (NRT) for tobacco use disorder and buprenorphine for opioid use disorder. For more information on NRT, see Part 10 of this manual.

Abnormal Involuntary Movement Scale (AIMS) testing or equivalent must be conducted on a regular basis for participants taking psychotropic medications with a known potential side effect

of tardive dyskinesia (TD) or other extra-pyramidal symptoms (EPS) and for all participants with a diagnosis of TD regardless of current medication regimen. Metabolic monitoring is conducted regularly for participants taking medications that increase risk of metabolic syndrome. This includes weight, body mass index (BMI), waist circumference, blood pressure, and pulse. Fasting blood glucose, lipids, and electrocardiography may also be ordered and monitored.

PROS with Clinical Treatment must offer injectable psychotropic medication administration as part of the Medication Management service. Injectable medications (IMs) include long-acting intramuscular naltrexone and other long-acting medications for co-occurring substance use disorders.

PROS programs must maintain dated and signed records of all medications prescribed.

Psychiatric Assessment

Service Definition

Psychiatric Assessment is designed to gather data concerning a participant's psychiatric history and current mental health symptoms, assess such data for determination of the participant's current mental health status, and identify the need for clinical treatment services.

Staff Qualifications

Psychiatric Assessment is conducted by psychiatrist or a nurse practitioner in psychiatry.

Guidance

While the initial Psychiatric Assessment must occur within 60 days after the participant enrolls in the Clinic Treatment component, it can be updated at any time during their episode of care.

Psychiatric Assessments may also be used for the purposes of initiating buprenorphine treatment for co-occurring opioid use disorder.

Health Assessment

Service Definition

Health Assessment is designed to gather data concerning a participant's medical history and any current signs and symptoms and assess such data to determine their physical health status and need for referral. This includes continued measurement of specific health indicators associated with increased risk of medical illness and early death, including but not limited to, blood pressure, body mass index (BMI), substance use, and tobacco use.

Staff Qualifications

Nurse practitioner, nurse practitioners in psychiatry, physicians, physician’s assistant, psychiatrist, or a registered professional nurse. Licensed Practical Nurses may also provide Health Assessment within their scope of practice under NYS law and under the supervision of a registered professional nurse, licensed physician, or physician assistant.

Guidance

While the initial Health Assessment must occur within 60 days after the participant enrolls in the Clinic Treatment component, routine health assessments may be provided when indicated to monitor health status during their episode of care.

If and when serious health risks are identified, the program must provide appropriate follow-up, including collaboration with the participant's Primary Care Provider, Medical Specialists, and Health Home Care Manager, if applicable.

Symptom Monitoring

Service Definition

Symptom Monitoring is designed to identify the ongoing effects of a participant's course of care. This service involves the continuous process of monitoring a participant's symptoms of mental illness, as identified in their individualized recovery plan, and their response to treatment, within the context of other support and rehabilitation services.

Staff Qualifications

Symptom Monitoring is conducted by LPHAs, and Professional Staff or Paraprofessional staff under the supervision of an LPHA.

Guidance

Informal monitoring of symptoms is something that happens daily in all PROS programs, including those without the Clinical Treatment component. The Symptom Monitoring service involves clear collaboration and communication with the participant and their collaterals to identify any changes in their mental health status, including an exacerbation *or* improvement in symptoms. It also includes conversations related to medication adherence, efficacy, and side effects. As with all individual (1:1) services in PROS, symptom monitoring must last at least 15 minutes in duration, giving the participant and practitioner time to discuss how the individual is doing, any concerns they have related to their symptoms or medication side effects, and identify next steps for addressing those concerns.

PROS programs must have an established process to ensure that information obtained through symptom monitoring is clearly communicated to the psychiatrist, nurse, or nurse practitioner in a timely manner.

PART 4: THE PROS TEAM

THE TEAM-BASED APPROACH

A team-based approach to mental health services is beneficial for participants *and* staff. These benefits include:

- Improved continuity of care through changes in staffing,
- Improved participant engagement in services, and
- Shared responsibilities amongst the team.

PROS programs use an interdisciplinary team-based approach to work collaboratively in support of each participant's recovery, ensuring actual integration between their rehabilitation, treatment, and employment services. Although any given participant may form a stronger relationship with certain team members, all members of the staff are expected to provide services to them and support their recovery.

In order to support the team-based approach, programs must establish policies and procedures that promote effective daily team communication and collaboration, particularly as it relates to any individual participant's status, needs, and services.

STAFFING DEFINITIONS & MINIMUM STAFFING REQUIREMENTS

Staffing Definitions

PROS teams are made up of paraprofessional and professional staff from a wide variety of disciplines and background. Staff qualifications, and whether a staff is categorized as paraprofessional or professional, impact which services a team member can deliver and supervise as well as what documentation they can complete or sign off on.

Paraprofessional Staff

Paraprofessional staff include the following:

- *Certified Peer Specialists and Credentialed Youth Peer Advocates* who are qualified by personal experience and are certified or provisionally certified and are supervised by a competent mental health professional;
- *Licensed Practical Nurses (LPN)* who are currently licensed or permitted as licensed practical nurse by the NYS Education Department and are supervised by a registered professional nurse, licensed physician, or physician's assistant; and
- *Other individuals* who are at least 18 years old, possess at least a high school diploma or high school equivalency certificate, and demonstrate six (6) months professional and/or personal experience in a mental health or human services field.

Paraprofessional staff must be supervised by Professional staff, unless otherwise indicated based on the type of service they are delivering.

Note that Student Interns may provide services in PROS under appropriate supervision. Unless otherwise qualified by degree and licensure, Student Interns would be classified as Paraprofessional Staff.

See Appendix B for specific qualifications specific qualifications related to degree, training, and certification for each of the above paraprofessionals and competent mental health professionals.

Professional Staff

Professional staff are qualified by credentials, training, and experience to provide supervision and direct services related to the care or treatment of persons with a designated mental illness diagnosis. Professional staff include the following:

- Certified Psychiatric Rehabilitation Practitioner (CPRP),
- Creative Arts Therapist (LCAT and CAT-LP),
- Credentialed Alcoholism and Substance Abuse Counselor (CASAC),
- Marriage and Family Therapist (LMFT and MFT-LP),
- Mental Health Counselor (LMHC and MHC-LP),
- Nurse Practitioner / Nurse Practitioner in Psychiatry,
- Occupational Therapist (OT-L and OT-LP),
- Pastoral Counselor,
- Physician (MD and DO),
- Physician Assistant,
- Psychiatrist (MD and DO),
- Psychoanalyst,
- Psychologist,
- Registered Professional Nurse (RN),
- Rehabilitation Counselor (CRC),
- Social Worker (MSW-LP, LMSW, and LCSW), and
- Therapeutic Recreation Specialist.

See Appendix B for specific qualifications related to degree, training, certification, permit, and licensure for each profession.

Competent Mental Health Professional

Competent mental health professionals include Professional Staff and Certified Peer Specialists or Credentialed Youth Peer Advocates with at least three years of direct experience providing peer support services. This designation or staffing level has been specifically defined for their ability to supervise the delivery of CRS – Peer Support Services in PROS, creating opportunities for in-discipline supervision.

Licensed Practitioners of the Healing Arts

LPHAs are a subset of licensed Professional Staff whose scope of practice qualifies them to make a recommendation for admission to PROS. LPHAs include the following (see Appendix B for specific qualifications related to degree and licensure for each profession):

- Licensed Marriage and Family Therapist (LMFT),
- Licensed Mental Health Counselor (LMHC),
- Nurse Practitioner and Nurse Practitioner in Psychiatry,
- Licensed Occupational Therapist,
- Physician,
- Physician Assistant,
- Psychiatrist,
- Licensed Psychoanalyst,
- Licensed Psychologist,
- Registered Professional Nurse (RN),
- Licensed Creative Arts Therapist (LCAT),
- Licensed Clinical Social Worker (LCSW), and
- Licensed Master Social Worker (LMSW) under the supervision of an LCSW, Licensed Psychologist, or Psychiatrist employed by the agency.

Program Size and Minimum Staffing Requirements

PROS programs are encouraged to hire a diverse team with professionals and paraprofessionals from different backgrounds. Programs must maintain practitioner and supervisory caseloads that are appropriate and reflective of a strong clinical rationale.

The ratio of program staff to registered participants is 1:14; however, all PROS programs, regardless of size, must maintain a minimum of three (3) Full Time Employee (FTE) consisting of:

- 1 FTE LPHA
- 1 FTE Professional Staff (in addition to LPHA)
- 1 FTE Employment Specialist

Programs with more than 42 participants on their census must meet the minimum staffing ratios described in Table 1.

Table 1 PROS Minimum Staffing Ratios

Staffing Requirement	Minimum Ratio	Additional Information
PROS Team	1:14	• This is the total ratio of PROS Team staff to registered participants, inclusive of paraprofessional and professional staff, based on the program's current CAIRS census. • This ratio is inclusive of all paraprofessional and professional staff employed on the PROS Team and delivering direct services to PROS participants, *excluding* the Psychiatrist or Nurse Practitioner in Psychiatry.
Professional Staff	1:34	• This is the total ratio of Professional staff to registered participants, inclusive of the required LPHA, based on the program's current CAIRS census. • This ratio is inclusive of all professional staff employed on the PROS Team and delivering direct services to PROS participants, *excluding* the Psychiatrist or Nurse Practitioner. • Professional staff included in this ratio *also count* toward the 1:14 ratio above.
Employment Specialist	1:100	• All PROS programs, regardless of size, must employ at least one FTE Employment Specialist. • Programs with a current CAIRS census >100 must increase their Employment Specialist FTE proportionally. For the purposes of operationalizing this requirement, for each additional 20 participants registered in the program, the Employment Specialist FTE increases by 0.2. • Employment Specialists are also counted toward the overall minimum staffing ratio of 1:14 • If the Employment Specialist meets the qualifications of a Professional Staff, they may also be counted toward the 1:34 Professional Staff ratio.

PROS program administrators and managers are encouraged to routinely review staffing patterns based on current census and the needs of participants in the program. Minimum staffing will be impacted by a program's CAIRS reporting compliance, and a failure to discharge participants in CAIRS will result in a higher staffing requirement than what a program may currently need. PROS programs may request a customized minimum staffing report via email from the OMH Rehabilitation and Treatment Services Unit, which will specify the minimum program staffing based on the current CAIRS census.

Additional Staffing Requirements for PROS with Clinical Treatment

PROS with Clinical Treatment must employ an adequate number of Professional Staff whose scope of practice includes restricted activities to meet the clinical needs of all participants enrolled in the Clinical Treatment component.[5] Such restricted activities may include:

- diagnosis of mental disorders,

[5] Scope of practice considerations: Not all staff designated as Professional in PROS will have these essential restricted activities in their scope of practice. When making recruitment and hiring decisions, program administrators should familiarize themselves with each profession's scope of practice, as defined by the New York State Education Department's Office of the Professions.

- assessment and evaluation,
- assessment-based treatment planning, and
- the provision of psychotherapy.

PROS programs are responsible for ensuring that licensed and otherwise credentialed staff have appropriate supervision based on their licensure or credential, as established by the New York State Education Department's Office of Professions.

PROS with Clinical Treatment must employ or contract with a psychiatrist or nurse practitioner in psychiatry and nurse (RN and/or LPN) to meet the psychiatry and medication management needs of all participants enrolled in the Clinical Treatment component. Participants who receive Medication Management through PROS must be seen by the psychiatric provider at least once every three (3) months.

Although there is not an established minimum FTE for psychiatry and nursing staff at this time, programs must have the capacity to:

- complete initial psychiatric and health assessments in compliance with required timelines,
- provide all clinical treatment component services based on individualized needs and preferences, and
- rapidly admit and assess individuals referred from inpatient, forensic, or emergency settings to ensuring that there is no lapse in psychiatric prescriptions.

Programs should consider what types of groups or classes they might want nursing and psychiatry staff to develop and run. Examples of health-related topics include but are not limited to diabetes management, food and nutrition, sexual health, and medication education and self-management.

The Role of the Employment Specialist in PROS

Employment Specialists play an important role in PROS programs, contributing significant value to the interdisciplinary team. Employment Specialists must have status as an equal member of the team, with compensation at a level commensurate with their education and experience. As such, Employment Specialists should take part in all team meetings and should be included in IRP reviews for their assigned caseload.

Employment Specialist Time in Community Standard

PROS Employment Specialists must spend at least 50% of their work hours off-site, in the community. However, in keeping with fidelity to the IPS model, OMH recommends that Employment Specialists spend at least 65% of their work hours off-site, in the community.

- Off-site, community locations include, but are not limited to, ACCES-VR offices, businesses, libraries, schools and colleges, coffee shops, participants' homes, training sites, and time spent traveling to different community locations.

- Off-site activities may include direct service provision including collaborative documentation, as well as job development activities, like networking with community employers.
- The time in community standard is not meant to include time spent in meetings at an agency's satellite offices or completing non-collaborative documentation outside of the program space.

The time in community standard does not imply that employment services cannot be provided at the program site. During the 35-50% of work hours when Employment Specialists are at the PROS program site, they may deliver any number of employment-related services. Examples of on-site employment services include, but are not limited to, resume writing, career exploration, work-related social skills development, motivational interviewing focused on work and school related goals, etc. In keeping with the IPS model, such services are not intended to be "prevocational" in nature and must be necessary to support competitive, integrated employment.

SUPERVISION

Supervision must be available to all staff providing services to ensure the success and quality of all PROS Services. Supervision by trained and qualified supervisors helps staff understand and respond more effectively to all types of clinical needs or scenarios. Ensuring regular availability and check-in with a professional supervisor supports quality care, staff morale and retention, and overall professional development.

It is a program's responsibility to make certain that all services are provided by staff within their scope of practice, level of competence, and under appropriate supervision, which is commensurate with their training, experience, and skills.

Specific supervisory requirements for each service are described in Part 3 of this manual. Supervision of services occurs both formally, through direct supervision and clinical consultation availability, as well as informally, through team meetings and recovery plan reviews. PROS programs must have a written and current staffing plan that indicates how supervisory requirements are met. This staffing plan must be made available to OMH upon request.

Direct supervision by a professional staff must be always available to assist and direct paraprofessional staff so they can address any issues related to quality of care in the provision of any PROS components. This means that a professional staff must be onsite during established operating hours as listed on the program's Operating Certificate. The program must establish a policy and procedure to ensure that paraprofessional staff who are working off-site, providing telehealth, or community-based services, have a method for quickly reaching a supervisor for urgent needs or concerns.

OMH strongly recommends that Certified Peers have access to in-discipline supervision, mentoring, and support from Peer Specialists/Advocates. This can be accomplished by connecting Peer Specialists/Advocates within the organization and supporting regular convenings. This can also be established in collaboration with local agencies or via contracting with peer-run agencies.

PART 5: SERVICE DELIVERY

PERSON-CENTERED APPROACH

PROS services are to be delivered using a person-centered practice approach that is strengths-based, recognizes each participant as an individual with their own dreams and aspirations, and focuses on tailoring service delivery to meet individualized needs *and* preferences. Each participant is engaged in a person-centered planning process to develop an Individualized Recovery Plan (IRP), which identifies the services needed to move them toward attaining their PROS goal. Whenever possible, services are delivered with respect to the participant's preference regarding days, times, and modalities that are convenient and best suited to reach their goal.

Person-centered practice does not negate or compromise the importance of medical necessity. Only medically necessary services can be counted toward the monthly claim. At times participants may express a strong desire or preference to attend a specific group or class because they have a close relationship with the facilitator, their friends are taking the class, they enjoy or are interested in the topic, it is scheduled at a time that is convenient for them, etc. In these instances, the program may want to consider adding recovery-oriented activities that would align with the participants' preferences.

INTEGRATED CLINICAL TREATMENT & REHABILITATION

INTEGRATING CLINICAL & REHABILITATIVE SERVICES

The goal of integrating clinical and rehabilitative services is to ensure that all a participant's services are working effectively together to advance them toward their goal(s). Clinical treatment providers and rehabilitation providers need to have a clear understanding of what each is doing to support the participant. When services are integrated, rehabilitative interventions can be maximized to support clinical engagement and shared decision-making, and clinical interventions can be maximized to support goal acquisition.

PROS with Clinical Treatment must have policies and procedures that describe how staff will collaborate to ensure integration of services. Programs should consider how staff supervision, the weekly team meeting, and tools and resources available in the electronic health record can be used to support effective integration.

Clinical Treatment Services Outside of PROS

Whether a PROS program offers the clinical treatment component or not, integration is critical. PROS programs must attempt to communicate and collaborate with outside treatment providers at least quarterly, or more frequently depending on the needs of the participant. All PROS programs must have policies and procedures that support integration with outside Clinical Treatment Providers, including:

- Identifying outside clinical treatment providers and including their contact information in the case record,
- Obtaining informed consent to release/receive information, and
- Ongoing exchange of information with outside providers.

When possible, the PROS program should review whether there are any rehabilitative services that can be offered to support the participant's clinical engagement and progress (e.g., skill building for medication self-management, identifying and addressing barriers to attending appointments, building shared decision-making skills, etc.).

Partnership with Commercial Laboratory Services

PROS with Clinical Treatment must provide or arrange for any blood analysis required as part of prescribing psychiatric medications.

COMMUNICATION, COLLABORATION, AND PROS TEAM MEETINGS

PROS programs must establish effective processes to promote daily team communication and collaboration, particularly as it relates to any individual participant's status, needs, and services. Each program, including those without the Clinical Treatment component, must hold at least one weekly team meeting for a minimum duration of 1 hour. The focus of the team meeting is on the current status and needs of participants. All members of the PROS team, including peer workers, should attend the team meeting whenever possible.[6] Team meetings must be attended by at least one LPHA and should be scheduled at a time when the psychiatric and nursing staff are available to attend as needed.

The team meeting must include a brief and clinically relevant review of every participant who is experiencing a significant increase in symptoms or who is at high risk of relapse (mental health or substance use). As time allows, the team meeting should also be used to discuss participants who are making significant progress toward an objective or goal and those who may need additional support or assistance.

The team meeting, as described above, is not intended to take the place of an administrative staff meeting (e.g., trainings and in-services, reviewing policies and procedures, introducing new staff, etc.). Programs *may* structure the team meeting to include LPHA supervision for services such as Individualized Recovery Planning and Symptom Monitoring, although additional time may be needed depending on the size of the program.

[6] Note that if a PROS program employs a recipient employee as a member of the PROS Team, the team meeting should be structured to support their attendance and participation as equal members of the PROS team. Clinical issues or concerns related to the recipient employee's treatment and services in the program should be discussed separately through supervision or another scheduled meeting.

PROS programs have shared that the use of a brief "team huddle" at the start of each day before participants arrive has been a helpful way to discuss and share important information. Team huddles do not replace the need for the team meeting as described above.

THE PROS SPACE

The PROS program space is the hub of services and activities. It is a welcoming space that is clean, accessible, and safe. The environment should be reflective of the community served in terms of ethnic and cultural background and age; for example, the literature, photos, and reading material are reflective of the population served. Programs should prominently display information about community resources and supports to support the acquisition of goals.

Programs may offer a variety of amenities and activities for participants to use while at the program (e.g., computer rooms, boardgames, libraries, etc.).

PROS programs must ensure:

- proper exit signs are visible and working and evacuation signage is posted;
- records are maintained confidentially;
- medications are stored appropriately;
- group rooms/ classrooms promote confidentiality;
- there are a sufficient number of restrooms and all are available and accessible to both staff and participants;
- rights and advocacy information are prominently posted;
- all signage is positive, welcoming, helpful and respectful; and
- suggestion/complaint receptacles are prominently displayed and invite ongoing and spontaneous feedback.

OMH recommends that PROS Programs:

- Display artworks and reading material available in the waiting area and common areas that promote recovery, such as posters that are inspirational, motivational, and hopeful, and written accounts of success stories.
- Provide private storage areas or other accommodations for participants' personal belongings.
- Prominently display *outcomes* from satisfaction surveys, suggestion boxes, and complaints, including actions taken by the program to improve services based on participant feedback.

COLLABORATIVE DOCUMENTATION

Collaborative, or concurrent, documentation is a process in which the PROS practitioner and the participant work together in the documentation of assessments, IRPs, progress notes, and monthly summaries. This practice supports the “nothing about us without us” philosophy of the recovery movement. Collaborative documentation facilitates shared decision-making, ensuring that the participant and the PROS practitioner are working with the same information and from a shared understanding.

PROS participants should be offered the opportunity to participate in collaborative documentation. Some may choose to only do so with certain documents (e.g., the IRP), while others may prefer that all documentation be completed collaboratively.

WORKING WITH MANDATED INDIVIDUALS

PROS programs are expected to comply with their county requirements on Assisted Outpatient Treatment (AOT) orders. Each program should have a clear understanding of how their county(ies) identify PROS services on the AOT treatment plans. PROS programs are required to comply with county AOT reporting requirements.

PROS programs must have a clear understanding of *significant events* for participants with an AOT order. Examples of significant events include but are not limited to arrest and incarceration, behavior that is dangerous to self or others, loss of housing, hospitalizations and emergency room visits, and non-compliance with mandated treatment. Significant events are described in the OMH Guidance for Reporting Significant Events. When a PROS program becomes aware of a significant event involving a participant with an AOT order, they must notify the health home care management entity as soon as possible to initiate the reporting procedure. The notification to the care manager must include as much detail as possible to support completion of the report.

PROS programs may also work with individuals that are mandated to receive mental health treatment through various avenues including but not limited to Drug Court, Department of Social Services, or Child Protective Services.

PERSON-CENTERED PRACTICE FOR MANDATED INDIVIDUALS

PROS programs should employ person-centered planning as a tool for engagement with individuals who are mandated to attend. For example, the program may:

- Offer the participant the opportunity to make informed choices from a menu of acceptable options within the context of their order.
- Offer the participant the opportunity to sign any documents and document their unwillingness to do so, when necessary. Note that for participants with an AOT order specifically, if they refuse to sign required documents, the signature requirement is considered waived for the purposes of compliance with PROS standards.

- Create a group/class schedule designed to set the participant up for success. Schedule their services at days and times that are convenient and preferable to them.

The PROS Team should be challenged to avoid using their own values and beliefs when developing goals and objectives and instead negotiate goals with the participant around real concerns related to their recovery. PROS goals for participants mandated to attend PROS may include but are not limited to getting off AOT, regaining custody of their child(ren), graduating from a halfway house or transitional residence, or improving their relationship with other providers.

EVIDENCE-BASED PRACTICES IN PROS

Evidence-based practices (EBPs) are interventions for which there is consistent, scientific evidence demonstrating their effectiveness to improve participant outcomes. EBPs are based in equal parts on the best research available, the expertise of the practitioner, and the needs and preferences of the participant. EBPs are selected and tailored to meet each participant's unique needs and preferences.

The PROS model is built on several key EBPs, some of which share names with specific PROS services. It is important to note that these EBPs can be infused throughout all service delivery and are not tied exclusively to the PROS service that shares its name. For example, the evidence-based application of Integrated Treatment for Co-Occurring Disorders would extend beyond the IR-IDDT service to include interventions under CRS – Complex Care Management and Clinical Treatment services.

All PROS programs must provide the following EBPs:

- Family Psychoeducation
- Integrated Treatment for Co-Occurring Disorders
- Individual Placement and Support (IPS)
- Wellness Self-Management (WSM)

PROS programs may also identify and employ a wide range of additional EBPs, including but not limited to Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Solution Focused Therapy, and Acceptance and Commitment Therapy. When EBPs are implemented, programs are responsible for ensuring that team members have sufficient training and certification, where applicable.

OFF-SITE AND COMMUNITY BASED SERVICE DELIVERY

All PROS services may be delivered off-site, when doing so supports the participant’s goal(s) and objectives. Off-site means any clinically appropriate location in the community, other than a licensed PROS site, where a participant may receive services. For the purposes of calculating the PROS Unit, off-site *does not include* any space that is co-located at the same address as the PROS program.

Community-based services can be valuable for exploring new environments and roles, particularly for participants who are still working on refining their goal(s). Staff can assess a participant's skill performance in real-world settings and identify any barriers in the environment. Community-based services provide the opportunity for staff to engage in skills programming, adapting their approach or identifying supports needed in community environments. When receiving services in the community, participants have the chance to practice newly acquired skills while also developing a sense of empowerment, belonging and inclusion.

Group-based community services can offer a valuable opportunity for participants to learn from each other in new and different environments, observing what works for others and benefitting from mutual support. When group-based services are delivered in the community, programs must take steps to ensure staff and participant safety, protect participants' privacy, and minimize the chance for stigmatizing experiences.

OMH strongly recommends lower staff-to-participant ratios when group-based services are delivered off-site.

INDIVIDUAL AND GROUP SERVICES

DURATION OF SERVICES

Individual services must be at least 15-minutes in duration. Group-based services must be at least 30-minutes in duration.

For more information on how units are accrued based on services and duration, please see the PROS Billing & Claiming Manual.

SERVICE RATIOS BASED ON COMPONENT

Table 3 below indicates staff-to-participant ratios based on component.

Table 2 Staff to Participant Group Ratios

Component	1:1 Service	Group Ratio
Community Rehabilitation & Support	Allowed	1:12 maximum * †
Ongoing Rehabilitation & Support	Allowed	N/A
Intensive Rehabilitation	Allowed	1:8 maximum * ‡
Clinic Treatment	Allowed	1:12 maximum *

*On occasion, a total of 3 participants at a time may audit onsite-based group for the purpose of:

- Making an informed decision as part of the pre-admission process; and

- Determining if a particular service would be useful in overcoming the participant's mental health barrier(s).

Participants who are auditing the group *do not* count toward the maximum ratios identified above. The program should follow these guidelines for participants who are auditing a group:

- A participant who is auditing a group is not a part of the group on a routine basis and is therefore only present for the purpose of observing.
- A group that a participant audits would not be identified on that their IRP.
- The group audited is *not* considered a billable service for the participant auditing.

† The only exception to group ratios for onsite CRS group/class sizes of between 13 and 24 members are permissible *if* the group is co-facilitated by at least two staff members, and there is documentation that the expanded group size is clinically appropriate for the group service type being provided. Note that both staff members must be actively involved in facilitating the group and engaging participants, which will necessitate advanced planning and coordination.

‡ The only exception to group ratios for Intensive Rehabilitation services is for Intensive Family Support/Family Psychoeducation. Such groups may include up to 16 group members if the group is co-facilitated by at least two staff members. Note that both staff members must be actively involved in facilitating the group and engaging participants, which will necessitate advanced planning and coordination.

EFFECTIVE GROUP/CLASS FACILITATION

Successful group/class-based services are the result of effective facilitation. An effective facilitator should:

- Understand the group/class materials of the service being provided and the expected outcome of the service,
- Be aware of each participant's goals and barriers to be addressed through participation in the group/class,
- Ensure that each participant understands what is expected from them and is engaged in the group/class,
- Regularly review with each participant how the services will address barriers to the achievement of their goals, and
- Teach materials, facilitate discussion, and implement opportunities for practice.

Facilitators must use a part of each group/class session to review how the material covered relates to the goals and/or objectives of group participants.

Group/class facilitators must also engage in trauma-informed practice and should be mindful when engaging in discussions that may be difficult or triggering to group members, including issues of diversity. In a group-based program, there will be times when participants' personal values and deeply held beliefs clash. Staff should be prepared to facilitate respectful dialogue and to support participants with working through disagreements, when possible.

THE PROGRAM SCHEDULE

OVERVIEW AND MINIMUM STANDARDS

PROS programs must have a current program schedule, and all previous program schedules must be archived and available upon request for a period of no less than six (6) years.

The program schedule is a dynamic document, always growing, adapting, and changing to meet the needs of program participants. To ensure that the program is keeping pace with the needs of all participants, the program schedule must be fully updated and reissued at least 3 times per calendar year. OMH strongly recommends that the program schedule should be fully updated and reissued at least 4 times per calendar year. The program schedule must also include daily opportunities for in-person group services.

By no later than 10/01/2025, the program schedule must include the following elements:

a) Start and end date for the current cycle,
b) Component and service type for each group or class (acronyms are acceptable),
c) Start and end dates for any class that does not start and end with the current cycle,
d) Modality (in-person, telehealth, or hybrid) for each group or class,
e) A variety of components and service types that reflect the current needs and goals of program participants, and,
f) A variety of recovery-oriented activities, as defined below.

Popular/ high-demand groups should be scheduled multiple times per week and at different times of the day.

RECOVERY-ORIENTED ACTIVITIES

Non-billable recovery-oriented activities are a key part of the PROS program; participants' time spent in the program should be engaging and meaningful, even when they aren't actively engaged in a medically necessary service. These activities are structured opportunities for participants to informally practice skills and engage with their peers. PROS staff may or may not be present for the duration of an activity but must be onsite and available in case of a crisis or emergency. Activities are typically offered in-person but may be made available remotely through telehealth for programs with telehealth approval. Examples of recovery-oriented activities include but are not limited to mutual aid or self-help groups, arts and crafts, and participant-led clubs (book clubs, video game clubs, knitting clubs, etc.).

PROS programs should create opportunities for participants to engage in peer leadership through developing and facilitating recovery-oriented activities. Solicit feedback from your Participant Advisory Board regarding the type of activities they'd like to see included on your program schedule.

GROUP CURRICULA

All PROS groups and classes are based on a planned, structured curriculum that follows a logical sequence with clear learning objectives. Curricula are often developed and/or adapted by PROS practitioners based on the needs of participants in the program.

By no later than 10/01/2025, PROS curricula must include the following required elements:

- Class/Group Name
- PROS Component and Service
- Learning Objectives or Anticipated Outcomes
- Duration (# of weeks or sessions)
- Lesson Plans for each session

Note that while many curricula are developed to align with the program schedule duration (e.g., groups/classes run for 12 sessions if the program schedule runs for 12 weeks), this is not a requirement. The duration for any given group or class may be longer or shorter than the current program schedule and should be based on the specific skills taught and the needs of the participants.

PROS SPECIALTY TRACKS

Together with the PROS participants and programs, OMH will be developing PROS Specialty Tracks which can be included on a program's operating certificate. Specialty Tracks are intended to support programs in specializing in serving specific populations or needs, developing their expertise, and improving outcomes for program participants. Programs may have more than one Specialty Track. Specialty Tracks are *not* intended to limit who a program serves, and PROS programs will not be required to obtain a Specialty Track; however, Specialty Tracks may make it easier for individuals, referral sources, and payers to identify the best program to meet their unique needs.

The licensing requirements for Specialty Tracks will be described in additional guidance. Programs that are interested in adding a Specialty Track may do so by submitting an Administrative Action.

PART 6: PRE-ADMISSION, INTAKE AND ASSESSMENT

PRE-ADMISSION SCREENING

Participants will engage in services for many different reasons, and present at various stages of change, with many different expectations, aspirations, and perspectives about their recovery journey. Individuals may come from a variety of referral sources, including self-referral. Pre-admission is a person-centered and trauma-informed process that can be used to support successful engagement. It is an *opportunity* for both the individual to learn what PROS is and for the PROS team to learn more about the individual, including their preferences for engagement and service delivery. Pre-admission gives the LPHA time to determine medical necessity and to make a recommendation for admission or non-admission. Pre-admission may look different at every program, but all programs must meet the following standards:

- The pace of pre-admission is person-centered, and individuals are not rushed to make a commitment, and
- Individuals are offered an opportunity to tour the program and audit groups/classes and activities as soon as possible and within one week of request of services (referral).

When appropriate, pre-admission sessions may occur via telehealth. However, the participant must be seen in-person at least once (onsite or off-site) *and* offered the opportunity to visit the program prior to admission where possible. If it is not possible for the individual to visit the program prior to admission, the program must document an explanation in the case record (e.g., if the individual is hospitalized at the time of admission).

OMH strongly recommends that programs offer same-day program tours, have various days and times available for screening and orientation, and mechanisms for appointment reminders.

Note that participation in PROS is voluntary, except when an individual is mandated through an AOT order. As part of the pre-admission screening process, PROS staff should discuss with the individual any co-enrollment restrictions that may impact their participation in other programs (see PROS Billing & Claiming Manual for details).

DOCUMENTATION OF PRE-ADMISSION SCREENING

All services during the pre-admission process must be documented. Such documentation includes all engagement efforts and should clearly demonstrate that the participant was given an opportunity to audit classes or groups and tour the program.

If an individual is *not* admitted to PROS, the following information must be included in pre-screening notes:

a) The reason for not admitting the individual,
b) Any referrals made to other programs or services, and
c) The dated signature of a professional member of PROS staff.

ADMISSION

RECOMMENDATION BY AN LPHA

The LPHA recommendation must be completed prior to or upon admission. Documentation of the LPHA recommendation must include:

a) An explanation of the medical need for PROS, and
b) The name, credentials, and dated signature of the LPHA making the recommendation.

If the LPHA making the recommendation is a member of the PROS team, the recommendation must include the PROS components that will initially meet the individual's needs and the LPHA must sign the screening and admission note.

An LPHA who is not a member of the PROS team and who is otherwise connected to the individual (e.g., a primary care provider) may make the recommendation for admission. If the LPHA making the recommendation is not a member of the PROS program staff, the recommendation must include their National Provider Identifier (NPI) or NYS license number.

Examples of *"medical need for PROS"* may include but are not limited to: increasing capacity to better manage treatments for diagnosed mental illness(es); preventing the worsening of symptoms; restoring or rehabilitating functional level; increasing ability to identify and advocate for effective supports; facilitating active participation in their community, school, work, or home environment; sustaining wellness and life skills; strengthening resiliency, self-advocacy, self-efficacy and/or empowerment; building and strengthening natural supports and family relationships; or, improving effective utilization of community resources.

SCREENING AND ADMISSION NOTE

A Screening and Admission Note is completed at the time of admission and must include the following required elements:

a) Reason for admission,
b) Primary service-related needs and services to meet those needs,
c) Admission diagnosis, and
d) Name, qualifications/credentials, and dated signature of a professional member of PROS staff.

Note: Programs may choose to streamline the LPHA Recommendation and Screening and Admission Note into a single document. This is acceptable if the form includes the required elements for both and is completed by a qualified LPHA.

PARTICIPANT RIGHTS

PROS participant rights are described in Part 512.10. PROS staff must provide the participant with information about their rights in a manner that is person-centered and mindful of their learning style. Participants must be provided a written notice of their rights prior to or upon admission. Programs must also display a copy in a common area of the program.

REGISTRATION AND ENTRY IN CAIRS

Upon admission, the individual must be registered in the Child and Adult Integrated Reporting System (CAIRS) for each component they will be participating in. The date an individual is successfully registered in CAIRS is their *admission date*. This begins the 60-calendar day timeframe for completion of all required assessments and the initial IRP.

Note that if a registration request is denied in CAIRS, the individual must be informed of the reason for the denial (as indicated in CAIRS). For example, a registration request may be denied if an individual is currently enrolled in Assertive Community Treatment (ACT). Whenever possible, the individual should be given information on co-enrollment restrictions and should be offered the opportunity to make an informed choice about which level of service to pursue. If their registration has been denied, the PROS program will need to discharge the individual and may readmit them if there is a change in their co-enrollment status. For more information on CAIRS, please see Part 12 of this manual.

INITIAL SERVICE RECOMMENDATION

The Initial Service Recommendation (ISR) is developed at admission in collaboration between the participant and the PROS team. The ISR must be developed under the supervision of an LPHA and must be approved and signed by the LPHA.

The ISR functions as an interim service plan prior to the completion of the initial IRP, identifying the primary service needs and a list of the services the individual will participate in. The ISR remains active for up to 60 days or until the initial IRP is completed, whichever is sooner.

The ISR must be updated if new services are added prior to the completion of the initial IRP; any updates to the ISR must be approved by the LPHA.

ASSESSMENT

The initial assessment process should build upon the engagement work done during pre-admission. PROS participants have shared that a person-centered, trauma-informed, and strengths-based assessment and recovery planning process is the key to their early engagement in the program. The process should include in-depth conversations regarding what the participant's goals are as it relates to participation in PROS as well as what their life might look like when they no longer need this level of service and support.

REQUIRED SCREENINGS AND ASSESSMENTS

Screening and assessment requirements are based on the participant's component registration. All required screenings and assessments must be completed within 60 calendar days of admission. Required initial *assessments* must include:

- The date(s) and method(s) of assessment (may be documented in the assessment tool itself or in a corresponding progress note),
- A narrative formulation summarizing the findings and recommendations which are to be prioritized for incorporation into the IRP, as appropriate, and

- The dated signature of the qualified staff who completed the assessment.[7]

The Screening for Risk of Harm to Self and Others does not require a narrative formulation, unless the screening is positive and results in the need for further assessment.

Note: Required screenings and assessments may begin during pre-admission.

Methods of assessment include but are not limited to interviews with the participant and collaterals, review of records from other providers or programs, review of laboratory findings or reports, direct observation by the practitioner, use of self-assessment tools or inventories, and standardized screening tools. PROS programs are encouraged to incorporate information from the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) in their assessment process. Note that interviews with collaterals and the use of PSYCKES both require appropriate informed consent.

Table 3 describes each assessment and screening, including qualified staff and required elements.

[7] Where applicable, if a paraprofessional staff completes an assessment or screening, the assessment must also be reviewed, approved, and signed by the supervising Professional staff.

Table 3 Assessment and Screening Requirements

Assessment or Screening	Qualified Staff	Required for Participants Enrolled in…	Required Elements
Alcohol, Tobacco, and other Drugs Assessment	Professional Staff	CRS, IR, CT Optional for ORS-only	• Screening for co-occurring substance use disorders, and if positive: ○ Collect history of use and current use ○ Formulate treatment recommendations and referrals if appropriate • Screening for tobacco use, and if positive: ○ Collect history of tobacco use and current tobacco use ○ Formulate treatment recommendations including the opportunity for Nicotine Replacement Therapy and referrals if appropriate
Screening(s) for Risk of Harm to Self and Others	Any PROS Team member who has received training to complete this screening	Any component	• Screening for risk of harm to self • Screening for risk of violence towards others • If either screening is positive, the program must conduct a discrete assessment that considers both static and dynamic factors in conjunction with current mental status, supports and protective factors. Access to means/weapons is emphasized.

Assessment or Screening	Qualified Staff	Required for Participants Enrolled in…	Required Elements

Comprehensive Psychiatric Rehabilitation Assessment	Professional Staff or Paraprofessional Staff under the supervision of Professional Staff	Any component
		
		For ORS-only, the program may choose to only complete the relevant/necessary sections for an employment focus.
			• Reason(s) for seeking services, including preliminary goal areas
			• Primary language needs
			• Review of the participant's daily routine, health status and history, employment status and history, educational status and history, housing status and history, current living arrangements, family and personal relationships, civic engagement, and hobbies and leisure activities
			• Identification and exploration of the participant's
			  ○ Beliefs about recovery and the possibility of change
			  ○ Strengths
			  ○ Current supports and resources
			  ○ Preferred learning styles (visual, kinesthetic, auditory, reading and writing)
			  ○ Current life roles and life roles they are interested in (e.g., parent, employee, student, tenant, friend, etc.)
			  ○ Current living, working, learning, and socializing environments, including areas of satisfaction and dissatisfaction
			  ○ Barriers encountered as a result of their mental illness
			  ○ Other barriers that are likely to impact program participation and readiness to change, including but not limited to any history of or current legal and/or forensic involvement
			• Assessment of task/ skill performance in natural environments as it relates to identified roles
			• Assessment of needed supports and resources

Psychiatric Assessment	Psychiatrist or nurse practitioner in psychiatry	CT	• Review of psychiatric history • Mental Status Exam for the purposes of diagnosis, treatment planning, medication, or other therapy • Recommendations related to the need for clinical treatment services

Assessment or Screening	Qualified Staff	Required for Participants Enrolled in…	Required Elements
Health Assessment	Nurse practitioner, nurse practitioner in psychiatry, physician, physician's assistant, psychiatrist, registered professional nurse. Licensed Practical Nurses may also gather data as part of the health assessment within their scope of practice under New York State law and under the supervision of a registered professional nurse, licensed physician, or physician assistant.	CT	• Review of medical history and current physical health conditions, including any recent medical hospitalizations or emergency room visits • Review of all medications currently taken (medication name, reason for taking, and current dose) and any reported side effects • Screening for metabolic syndrome, diabetes, hypertension, and any other physical health issues impacting the participant's mental health recovery • Review of current medical providers, including primary care provider and any other medical specialists involved in the participant's care; this assessment process may include discussion with the participant related to informed consent to release/ receive information with other providers and to access PSYCKES • A review of any available medical documentation or records, including PSYCKES Clinical Record (with appropriate consent) • Screening to determine whether the participant has or is interested in establishing a health care proxy, power of attorney, or advanced directives
Employment Interest Interview*	PROS Employment Specialist	Any component This interview is required for any participant who expresses an interest in employment during the Comprehensive Psychiatric Rehabilitation Assessment	• Discussion of the participant's needs and priorities as it relates to employment • Exploration of their employment history and interests, including previous work experience • May also include review and discussion of current public benefits (SSI, SSDI, Medicaid, TANF, SNAP, etc.) and a review of access to documents necessary for employment (state-issued identification, social security card, etc.)

The Alcohol, Tobacco, and Other Drug Assessment

The Center for Practice Innovations (CPI) Learning Community includes a number of modules on screening and assessing for co-occurring substance use and addiction disorders. OMH has not required a specific screening or assessment tool to be used for this assessment.

If a participant is assessed to have an addiction or substance use disorder that cannot be adequately treated in PROS, the program must make appropriate linkages and referrals to an outside treatment provider (e.g., an OASAS-certified Opioid Treatment Program). The PROS should coordinate ongoing services with outside providers to ensure an integrated approach to treating co-occurring disorders.

Comprehensive Psychiatric Rehabilitation Assessment & Employment Interest Interview

The Comprehensive Psychiatric Rehabilitation Assessment is the primary way that PROS programs learn about a participant's interests, preferences, and needs. This assessment must be conducted through a culturally sensitive and trauma-informed approach. The practitioner should explore elements of the participant's cultural background, particularly as it relates to life roles. The assessment should include data and information received from collateral contacts, when appropriate. This assessment will significantly inform the individualized recovery planning process.

When completed during the intake/admission process, the comprehensive psychiatric rehabilitation assessment includes an initial assessment of task and skill performance and needed supports and resources. Programs should use the Psychiatric Rehabilitation Assessment and Individualized Recovery Planning *services* to continually assess these areas and update the IRP as needed.

The PROS team should make every effort to assess how the participant is performing in the environment(s) of their choice. This could involve an in-person or audio-visual telehealth assessment in their home, school, or workplace. In addition to assessing the participant's skills in those settings, the practitioner should also make note of any environmental barriers or resources which may impact the participant's pursuit of their goal.

Employment Interest Interview

When a participant expresses an interest in employment during the Comprehensive Psychiatric Rehabilitation Assessment, the Employment Interest Interview should be completed as soon as possible so that the participant and the Employment Specialist can connect and explore their interest in pursuing an employment goal. In these cases, the Employment Interest Interview must be completed no later than 30 days after the completion of the Comprehensive Psychiatric Rehabilitation Assessment.

The Employment Interest Interview is not a formal assessment service. It should be completed for participants who have expressed an interest in employment. Depending on how the Employment Specialist conducts the interview, it *may* be billable as CRS – Psychosocial Rehabilitation or CRS – Individualized Recovery Planning.

Assessing for Telehealth

Programs with approval to deliver services through telehealth must assess participants for appropriateness for telehealth prior to delivering services in this modality. For more information related to telehealth, please see Telehealth Services Guidance for OMH Providers.

PART 7: INDIVIDUALIZED RECOVERY PLANNING

PERSON-CENTERED PLANNING & THE IRP

Person-centered planning is a collaborative process where the individual participates in the development of the goals and planning for services to the greatest extent possible. Person-centered services start with an Individualized Recovery Plan (IRP) that is created using the participant's own language and is consistent with the person's values, culture, beliefs, and goals. It is important to support a participant's personal motivation for seeking services and to ensure recovery planning remains non-judgmental and free from bias.

The person-centered planning process focuses on what the participant is saying and their framing of the problems and potential solutions. The practitioner is active in guiding, reframing, raising discrepancies, and offering compassion and hope by taking what the participant is saying and translating that into a plan of action that recognizes the participant as an individual. Person-centered planning is strengths-based. Focused attention should be given to understanding and addressing the impact of the social determinants of mental health and wellness, including housing, income/finances, and impact of discrimination.

The IRP is a personalized, culturally sensitive, goal-driven service plan created in partnership with the participant. This person-centered process is intended to engage the participant in a discussion of their:

- recovery vision and PROS goal(s),
- strengths and resources,
- barriers and needs,
- preferences for service delivery (including days, times, staffing, etc.), and
- how specific services will be used to support attainment of their goal.

Individualized recovery planning is both a discrete PROS CRS service and a collaborative process that results in the written IRP.

Programs must make a copy of the most current IRP available to the PROS participant.

DEFINING TERMS AND CONCEPTS

Recovery Vision: A statement that expresses the participant's long-term desire for positive change and improvement in their lives, ideally captured in their own words. It might answer the question, "What does a life in recovery look like for me?" or "Where do I want to be five years from now?" For example:

- I want to buy my own house with a yard.
- I will have custody of my children and will be able to give them a stable home.
- I want to work fulltime at a job with benefits and that pays enough to afford my bills.

PROS Goal: A statement that clearly describes what the participant's goal is as it relates to participation in PROS. PROS goals may include but are not limited to exploration and developing readiness, pursuit and maintenance of valued life roles, and improving or enhancing quality of life. The PROS goal may or may not be the same as the participant's recovery vision, but it should be meaningfully related.

Objective: Something the *participant* will do or accomplish as a step toward achievement of the goal. Objectives should address identified barriers to the goal and should drive the IRP forward. Objectives should

answer the questions: How will you achieve that? What steps will you take? When will you take them? Who will help you? For example:

- Over the next 3 months, I will increase my knowledge of different residential programs and housing vouchers.
- Over the next 3 months, I will create and stick to a household budget.
- Over the next 6 months, I will learn and use structured problem-solving skills to solve daily problems and make better decisions.
- Over the next 6 months, I will find and apply for at least 2 jobs per week.

Collateral: Collaterals include the participant's family, family of choice, and others significant in their life or integral to their PROS goal, who provide a direct benefit to the participant. Services may be delivered to collateral in accordance with the participant's IRP, and for the purpose of advancing their goals and for coordination of services with other community behavioral health and medical providers.

IDENTIFICATION OF FAMILY OF CHOICE AND OTHER COLLATERALS

Family of choice and other collaterals are a key factor in supporting a participant's recovery. Collaterals should be identified through person-centered planning, with the opportunity for the participant to make an informed decision about communication and collaboration with the collateral. With the participant's consent, collaterals may be included in the individualized recovery planning process and/or may receive other PROS services for the direct benefit of the participant. Collaterals must be identified in the case record in advance of any services being delivered to them; they may be documented in the IRP or elsewhere in the case record. The provider is responsible for maintaining a Consent to Release/Receive Information in the participant's case record prior to sharing or receiving any information with collaterals.

GOAL SETTING IN PROS

PROS goals are elicited through the person-centered planning (or individualized recovery planning) process. This goal statement gives a clear direction to the participant and the PROS Team about why this person is engaged in the program and what they hope to accomplish through their participation in services. Setting a meaningful PROS goal will drive the IRP, ensuring that PROS services and interventions are aligned with achievement of their goal and objective(s). While PROS goals are not always measurable, the team and the participant should have a clear, mutual understanding of what it will mean to accomplish the goal.

As the participant learns, grows, and explores the meaning and possibility of recovery in their life, their PROS goal may change or be refined. Each IRP review presents an opportunity to talk about the participant's recovery vision and goal(s), making updates as needed.

THE GOLDEN THREAD

Findings from the assessment process should inform the initial IRP, demonstrating medical necessity. The connection between assessment, recovery planning, and documentation of services is often referred to as "the golden thread." As new information related to the participant's needs and barriers is learned over time, that information needs to be documented (e.g., in Monthly Summary Notes, the Individualized Recovery Plan, or an updated assessment). Subsequent IRP revisions and updates should be informed by both the formal assessment process and new information documented in the case record. When a supervisor, new staff person, or reviewer reads a participant's case record, the golden thread should be evident throughout documentation.

INDIVIDUALIZED RECOVERY PLAN (IRP) REQUIREMENTS

The initial IRP must be developed after completion of all required assessments and within ***60 calendar days*** of admission to the program.

The IRP should be written in language that is understandable and meaningful to the participant. PROS practitioners need to balance the language of medical necessity and the language of recovery, avoiding medical or clinical jargon and capturing as much of the participant's language as possible.

The IRP must include the following required elements:

a) Participant's name, including preferred name, when applicable,
b) Recovery vision and PROS goal(s),
c) Objectives that are measurable, have target dates, and clearly represent steps toward the achievement of the participant's service goal(s),
d) Criteria to determine when goals and objectives have been met so that the participant can move forward in their recovery process,
e) Strengths,
f) Supports and resources,
g) Mental health barriers and needs,
h) Other barriers and needs as it relates to goal attainment (e.g., environmental, medical, or legal barriers),
i) Specific PROS services to be provided, including type and frequency,
j) The identification of any collaterals who will assist the participant in their recovery,
k) An indication of whether the participant has any advanced directives, and if so, where they can be found in the event of an emergency or crisis,
l) Name, title, and credentials/qualifications of the staff member developing the IRP, and,
m) Staff and participant signatures as described below.

For examples of the above required elements, see Appendix D.

Any service provided on a regular and routine basis needs to be documented in the IRP to support medical necessity. In keeping with the practice of psychiatric rehabilitation, services should be planned and included to address a specific barrier.

IRP Approval & Signature Requirements

The initial IRP and all subsequent updates/reviews must be approved by the participant and the LPHA.

The following signatures must be obtained within seven (7) calendar days of the date that the IRP is developed:

a) PROS participant,[8]
b) Staff member who developed the IRP,
c) LPHA reviewing and approving the IRP, if the staff member who developed the plan is not an LPHA.

[8] In situations where the participant is out of contact with the program due to hospitalization or other issue, the circumstances must be documented in the case record and their signature should be obtained upon their return to the program. See exceptions outlined in Operations Manual.

The inclusion of the LPHA's signature on the IRP is a representation that the identified PROS services are deemed to be medically necessary. An IRP is considered completed when the staff who developed the IRP, the participant, and the LPHA have signed it.

For participants receiving Clinical Treatment (CT) Medication Management services through PROS, the psychiatrist or nurse practitioner in psychiatry must also review and sign the initial IRP and all subsequent updates/ reviews as soon as practicable and no later than 30 days after it is developed.

Exceptions related to Participant Signature on the IRP

Signing the IRP is an empowering act that places the participant in the driver's seat of their recovery. The participant's *approval* of the IRP is required by regulation. In situations where the participant is out of contact with the program due to hospitalization or other issue, the circumstances must be documented in the case record.

When a participant chooses to receive services remotely through telehealth, PROS programs must make a good faith effort to obtain their signature on the IRP. Participant signatures may be obtained through secure electronic signatures, mail, off-site sessions with the participant, or by encouraging the participant to receive occasional services on-site where they can review and sign the IRP in-person. If these options are not viable, or if the time that these options take exceeds seven (7) days from the date the IRP is developed, the PROS program must document the participant's verbal approval of the IRP in the case record in lieu of a signature within seven (7) days.

In the event of an exception, the programs must obtain the participant's signature on the IRP upon their return to the program and document all attempts to obtain the participant's signature in the case record.

IRP REVIEWS

The IRP review is a collaborative process of reviewing the participant's progress towards goals and objectives, concerns with the current plan, or other items that they would like to share. The IRP review process also opens the conversation for reassessment to ensure that the services identified meet the needs of the participant. Occasionally, the IRP review may identify the need to review and update the participant's initial assessments.

6-Month IRP Review Process and Documentation Requirements

The IRP is reviewed and updated every six (6) months through a routine IRP review process. This process includes an individualized recovery planning meeting with the participant and any collaterals the participant wants to invite. The review should be scheduled at a time that is convenient for the participant and their collaterals. The PROS staff are responsible for facilitating a discussion of the participant's goal(s) and objectives, progress that has been made over the previous 6 months, current services and group schedule, and any changes recommended by the participant, the program staff, and/or collaterals.

This routine review and update should result in a new IRP reflective of the participant's progress or lack of progress toward their goal and must be signed by all required parties (as described above).

In situations where the participant is out of contact with the program due to hospitalization or other issue, the circumstances must be documented in the case record and the IRP review may occur immediately upon their return to the program.

Each routine IRP review must be documented in a review summary, which includes:

a) the date the IRP was reviewed with the participant,
b) identification of all staff members and collaterals who were involved in the review, and
c) justification for any changes made within the IRP and/or justification for parts of the IRP that will remain the same for the next review period.

This review summary may be documented in a progress note or elsewhere in the case record.

The IRP and Significant Life Events

When a participant experiences a significant life event, the PROS program must review the current IRP as soon as possible and no later than seven (7) calendar days from the date the event is discovered, to determine if the current goal(s), objectives, and/or services are appropriate to meet the participant's current needs. Examples of significant life events include but are not limited to:

- goal attainment,
- a move to a new home or residential setting,
- a loss of housing,
- a change in employment status or educational attainment,
- a change in relationship status or household composition,
- a recent hospitalization, or
- a new or revised AOT order.

Whenever possible, this review must include a person-centered discussion with the participant. Documentation of the significant life event and the subsequent review may be documented in a progress note, non-billable note, or elsewhere in the chart. An IRP review completed subsequent to a significant life event is focused solely on whether changes are needed based on the event; as such, this process may or may not result in an updated IRP. If changes are required, the updated IRP must be signed by all required parties and within required timeframes, as described above.

If an IRP requires a full review and update as a result of a significant life event, the PROS program may adjust subsequent review dates. For example, if an initial IRP is completed on 01/01/2025, the next review would be due by 07/01/2025. However, if there was a significant life event in March 2025 which resulted in a fully updated IRP on 03/15/2025, the next routine IRP review may be moved to 09/15/2025. Programs should use caution in moving IRP review dates, as the significant life event review is often narrower in scope and may not result in a full update to the IRP.

INDIVIDUALIZED RECOVERY PLANNING FOR PARTICIPANTS ENROLLED IN MULTIPLE PROS PROGRAMS

Participants are allowed to enroll in more than one PROS program, but they cannot receive the same components from two different programs. When this occurs, the participant may receive CRS and/or CT services from one PROS, and IR or ORS services from another PROS. The two PROS programs must work together to build an integrated IRP. If a participant is receiving PROS services from multiple PROS providers, then the provider of the CRS services will be responsible for forwarding copies of the IRP and any updates to the provider of the IR or ORS services. The provider of the IR or ORS services will be responsible for developing an IR or ORS plan which will be a component of the IRP and is consistent with the IRP developed by the provider of the CRS services.

SERVICES NOT INCLUDED IN THE IRP

At times, PROS programs may identify the need for a new service that was not included on the IRP, often in response to an urgent situation or crisis. When this occurs, the staff who provides the services should clearly describe the need for the service or rationale for providing it in the narrative of the progress note (documentation of service delivery).

If the new service is one which requires supervision by a Professional Staff or LPHA, the qualified supervisor must be involved in making the decision to provide the service (e.g., a paraprofessional staff should not make the decision to provide IR – Relapse Prevention without consulting a professional staff). If the service is or will be needed on a regular and routine basis, it must be approved by an LPHA and added to the IRP. This may be done through a progress note or "service addition form," which must be signed by participant, the staff person writing the note, and the supervising LPHA within 7 calendar days.

PERSONAL WELLNESS & SAFETY PLANNING

PERSONAL WELLNESS PLAN

The personal wellness plan, previously referred to as a relapse prevention plan, is an individualized tool that supports a participant's understanding of their individual factors which may trigger a recurrence of severe mental health symptoms and identifies ways to cope with the potential for recurrence. It includes a description of the participant's preferences regarding treatment and any PROS services that may be used in the event of a crisis. The personal wellness plan is optional but encouraged.

Best Practice Tip: The personal wellness plan should be developed at a time when the participant is doing well in their recovery. Doing so takes a significant amount of time and effort and should not be completed in a single session. Wellness Recovery Action Planning (WRAP) is an example of a personal wellness plan that could be developed in PROS.

SAFETY PLAN

The Safety Plan is an empathetic, situational response based on a *specific* identified risk. The Safety Plan is only required if and when a participant is identified as being at medium or high risk of harm to self or others.

A Safety Plan is always developed in collaboration with the participant and should take into consideration:

- Warning signs (thoughts, feelings, physiological),
- Coping strategies that they can do independently,
- Places and people they can go to feel safe,
- Professional contacts who can provide support, and,
- Ways to ensure that their environment is safe.

With appropriate consent, the Safety Plan should be shared with the participant's family of choice and other behavioral health providers (e.g., housing, clinic, etc.). PROS programs are encouraged to consider uploading the participant's safety plan to PSYCKES so that it can be readily accessed by other providers.
Safety Plans must be reviewed, and updated if needed, following any behavioral health hospitalization or emergency room visit.

PART 8: DOCUMENTATION OF SERVICES

DOCUMENTATION OF 1:1 AND GROUP SERVICES

All billable services, whether provided individually or in groups, must be documented contemporaneously, at the time of service delivery or shortly thereafter.

INDIVIDUAL SESSION SERVICE NOTES

Documentation of 1:1 service delivery must include the following required elements:

a) Name of individual receiving services,
b) Component and service provided,
c) Date of service,
d) Duration of service, including start and end times,
e) Location of service (on-site, community-based location, or in the person's home),
f) Modality (in-person, audio-visual telehealth, or audio-only telehealth),
g) Narrative descriptions of intervention(s) provided and how the individual responded to the service, and,
h) The name, qualifications, and dated signature of PROS staff delivering the service.

Individual session notes, or “progress notes,” *do not* need to be signed by the supervisor.

DOCUMENTATION OF GROUP OR CLASS SERVICE DELIVERY

Documentation of each group or class is required to support Medicaid claiming and to support the team-based approach to service delivery in PROS. Documentation of group- and class-based service delivery must include the following required elements:

a) Names of individuals receiving services,
b) Component and service provided,
c) Date of service provided,
d) Duration of service, including start and end times for each participant attending the group or class,
e) Location of service (onsite or community-based location)
f) Modality (in-person, audio-visual telehealth, or audio-only telehealth)
    i. For hybrid groups that involve more than one modality, the note must indicate the modality for each participant and/or collateral.
g) The name, qualifications, dated signature of the staff person delivering the service.

OMH does not require traditional group note narratives. However, programs must establish a policy and procedure to support clear and consistent communication to ensure:

- that other staff would be able to cover the group in the event of a facilitator absence (i.e., they would know which curriculum to use and what lesson the group is on), and
- that the team has an understanding of participants’ progress and level of participation in the group.

DOCUMENTATION OF SERVICES TO FAMILY OF CHOICE AND OTHER COLLATERALS

In addition to meeting all the required elements for 1:1 and group-based service notes, documentation of service delivery to collaterals must include:

- the name of the collateral,
- their relationship to the participant, and
- a description of how the service helped support or advance the participant's IRP.

MONTHLY SUMMARY NOTES (MSN)

The process of writing and reviewing the MSN should meaningfully engage the participant around identifying progress made and next steps. This note supports the monthly claim for services in PROS. Monthly Summary Notes may be completed by paraprofessional staff.

The MSN includes the following required elements:

a) The timeframe (start and end dates) covered by the note,
b) A brief description of the participant's engagement and participation in PROS,
c) A summary of the progress made (or not made) towards objectives identified in the IRP, subsequent to the previous MSN,
d) Identification of any emergent needs or significant life events not otherwise documented in the case record,
e) Documentation that the summary note was reviewed with the participant,
f) A description of next steps, when applicable (e.g., identification of complex care management needs or changes to their group/class schedule and the IRP), and
g) Dated signature of the staff member completing the MSN.

When summarizing a participant's progress (or lack thereof), this section of the note should include the participant's perspective on their progress or lack thereof whenever possible. This can be achieved through a collaborative documentation process.

An MSN must be completed, at a minimum, once each calendar month. For example, if a note is completed on July 15th, the next note could be completed as late as August 31st. MSNs are typically completed approximately every 28-30 days. The case record must include MSNs covering the entire timeframe that a participant is enrolled in the program. In the example above, if the note was completed on August 31st, the timeframe for the note should go back to July 16th to ensure that all of the participant's engagement and progress has been captured.

For examples of the required elements, please see Appendix D.

NON-BILLABLE CASE NOTES

PROS providers may conduct outreach, engagement, and collateral contacts that do not meet billing criteria. It is important to document any information pertinent to the participant's services, such as outreach and attempts to re-engage the participant during gaps in services. Non-billable contacts may be documented in a contact log, case note, non-billable progress note, and/or in the MSN. Programs have discretion in which non-billable contacts are documented. For example, routine appointment reminder calls or texts might not be documented, but a letter attempting to outreach to a disengaged participant should be noted.

PART 9: DISCHARGE PLANNING & PROCESS

DISCHARGE PLANNING

Effective discharge planning is an extension of the person-centered planning process and is critical to the participant's ongoing recovery; discharge planning begins at intake and is ongoing throughout the participant's enrollment in the program. There are many reasons a participant may be discharged, including but not limited to achieving their goals, transitioning to another provider, disengagement, or loss of contact.

The individualized recovery planning process naturally involves discharge planning, and as the participant builds skills and increases self-efficacy, it will become a more central part of the conversation. A "successful" discharge and goal acquisition are not necessarily the same thing. Discharge should be considered when a participant is confident in their skills and ability to achieve and sustain valued life roles independently or through a different level of support.

DISENGAGEMENT

Disengagement may indicate dissatisfaction with services or may be related to other life circumstances, including a change in mental health status. Programs must have a policies and procedure that describes what they will do if a participant begins to disengage from PROS unexpectedly or without advanced planning. For participants who become disengaged from the program, efforts to re-engage the participant must be commensurate with the degree of assessed risk. This may include the use of telehealth, making home visits, outreach to collaterals, and written correspondence with the participant. PROS programs must keep the door open to re-engagement. Any time a participant is discharged from PROS, they should be notified that they may re-engage in services at any time if needed.

TRANSITIONING CARE APPROACH

When appropriate, programs may offer a "transitioning care approach" for participants who have achieved their PROS goal(s) and are preparing for discharge. With this approach, participants enrolled in PROS can slowly transition out of the program by reducing frequency and intensity of services but will still have access to Clinical Treatment services, individual sessions, peer support, transition groups, and access to facilities.

Transitioning care is not intended to suggest that participants will need PROS services ongoing or indefinitely. It should be rare that a participant remains in transitioning care for a period longer than 6 months.

The transitioning care approach to discharge is optional; at this time, programs are not required to employ this approach.

Benefits of Transitioning Care Approach

The benefits of the transitioning care approach include but are not limited to:

- Celebrating the participant's success as they enter transitioning care and prepare for formal discharge;
- Employing a stagewise approach to discharge that promotes stronger community connections;
- Easing the transition and discharge process for participants who have come to rely on PROS over the course of several years and for whom discharge provokes anxiety or trepidation;
- Flexibility for the program to focus on goals and objectives that support discharge planning and maintaining life roles; and,

- Supports programs and participants that face local barriers to discharge, including but not limited to waiting lists at clinical treatment providers.

PROS Services While in Transitioning Care

The following services may be appropriate for participants receiving transitioning care:

- CRS – Individualized Recovery Planning
- CRS – Peer Support
- CRS – Engagement in Recovery
- CRS – Complex Care Management
- IR – Integrated Treatment for Dual Disorders
- CT – Clinical Counseling and Therapy
- CT – Medication Management
- CR – Symptom Monitoring
- ORS – Ongoing Rehabilitation and Support

While the above list does not restrict participants in transitioning care from accessing other medically necessary services in PROS, it is intended to illustrate the more limited scope that is expected for participants at this level of care. With very few exceptions, IR – Goal Acquisition, Family Psychoeducation/ Intensive Family Support, and Intensive Relapse Prevention would not be appropriate for a participant in transitioning care.

ORS & Transitioning Care

ORS is not time-limited, and participants may receive ORS for as long as it remains necessary to support their employment and education related goals. Participants who are only receiving ORS may be in transitioning care if preparing for imminent discharge.

Documenting Continuing Care

When a participant begins transitioning care, the IRP must be updated to reflect their change in services. The participant's PROS goal must be updated and may reflect maintaining their current life roles and/or making effective connections to other supports and services.

While there is no time limit on the transitioning care approach, documentation in the IRP and MSNs must clearly demonstrate how the program is supporting the participant with transitioning to another level of service.

The program must update the participant's CAIRS registration to accurately reflect any changes to their component registration. For example, if a participant is transitioning their clinical treatment services from PROS to a local outpatient clinic but will continue receiving CRS and ORS for a period of time, the program must discharge the participant from the Clinic Treatment Component, changing their RE codes from 84/86 to 85/86. This will prevent any billing issues for their new clinical provider while ensuring that PROS can still bill for the remaining services.

Program Requirements

Programs that choose to use the transitioning care approach must develop a policies and procedures on transitioning care, which includes an internal tracking system for keeping a current roster of participants who are in transitioning care. The policies and procedures must include updating the roster, and a method for

determining when a participant is ready for official discharge in CAIRS. Programs must review the roster of participants in transitioning care at least once per quarter in the required team meeting. The roster must be made available to State reviewers upon request.

Participants in transitioning care must be allowed to resume full engagement in PROS if needed based on a change in their mental health status, life role(s), or other goals.

OMH recommends the following as it relates to transitioning care:

- The participant's identified collaterals, including family of choice and other service providers, should be notified when a participant begins transitioning care.
- If there is, or will be, a need for ongoing care coordination services and the participant is not already connected to care management services, the PROS programs should make this linkage as soon as possible.

DISCHARGE PROCESS

When the decision is made to begin discharging a participant from PROS, the team will include the participant and any identified collaterals in discussions around what supports and services they may need to continue their recovery journey. The team and participant should identify any referrals that will be needed, coordinate with other service providers, and ensure that natural supports and community resources are in place.

Whenever possible, if the participant has developed a personal wellness plan and/or safety plan, these plans should be reviewed with them prior to discharge.

OMH strongly recommends that PROS programs contact individuals one-month post-discharge to ensure connection to services and supports and determine satisfaction with services and progress made.

DISCHARGE SUMMARY

Upon discharge, the PROS program is responsible for completing a discharge summary which includes the following required elements:

a) Date of discharge,
b) Reason for discharge,
c) Summary of progress (or lack thereof) while enrolled in PROS,
d) Referrals made for the participant, and
e) The dated signature of the staff completing the summary.

The discharge summary must be completed at the time of discharge. For individuals who are discharged from a PROS program and referred to another provider licensed by OMH, the discharge summary must be shared with the receiving program within two weeks. When applicable, the discharge summary must also be shared with the Health Home Care Manager.

PART 10: SUPPORTING WHOLE HEALTH & WELLNESS

Research has consistently found that adults with serious mental illness have a significantly shorter life expectancy than the general population (de Moojj, et al., 2019). The reasons for these premature deaths are often attributed to cardiovascular disease, tobacco use, and metabolic disorders. Physical comorbidities are often exacerbated by social risk factors, co-occurring addiction disorders, cognitive impairments, and mental health symptoms that disrupt routine access to preventive care. PROS programs must be well-versed in supporting participants with medical comorbidities to make substantive quality of life improvements in the lives of people they support.

SOCIAL DETERMINANTS OF HEALTH AND MENTAL HEALTH

The Centers for Disease Control and Prevention (CDC) defines social determinants of health (SDOH) as "the conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life-risks and outcomes" (2020).

The PROS model directly impacts the social determinants of health and mental health in participants' lives. The comprehensive psychiatric rehabilitation assessment and individualized recovery planning process are designed to support participants and staff in identifying and addressing social and environmental barriers to recovery goals.

STRATEGIES AND PROGRAM STANDARDS TO PROMOTE PHYSICAL HEALTH AND WELLNESS WITHIN PROS

COLLABORATION WITH PHYSICAL HEALTH PROVIDERS

PROS programs should collaborate with primary care and other medical specialists to the extent practicable.

Programs must implement policies and procedures to support collaboration with physical health providers. By no later than 10/01/2025, PROS programs must at a minimum:

- Ask every newly admitted participant if they have a primary care provider as part of the assessment and recovery planning process.
- If the participant *does not* have a primary care provider, the PROS program must offer to make a referral.
- If the participant *does* have a primary care provider:
    - The program must *request* a consent to release/receive information with the primary care provider, compliant with HIPAA regulations; the participant is not obliged to sign the consent and should be given the opportunity to make an informed and meaningful choice.
    - With appropriate consent, the program must notify the primary care provider that their patient has been admitted to PROS and *request* a copy of the participant's most recent physical exam, any related lab reports, and a record of any current prescription medications.

The above process may be incorporated into the Health Assessment for PROS with Clinical Treatment. It may also be incorporated into the Individualized Recovery Planning process and development of the initial IRP.

OMH recommends that programs make every effort to maintain ongoing communication and coordination with primary care providers and other physical health providers, particularly if a participant presents with medical comorbidities.

SUPPORTING HEALTH RELATED GOALS

PROS can support participants goals and objectives related to their physical health and wellness, including but not limited to:

- Managing chronic and acute health conditions
- Fitness and exercise
- Weight loss/management
- Creating healthier routines, including diet and nutrition
- Reducing or abstaining from tobacco, alcohol, and/or other drugs

The key to setting health-related goals and objectives in PROS is that they need to be person-driven and meaningful to their mental health recovery. The PROS Team should explore with participants the motivating factors behind their health-related goal (i.e., the impact of their health status/condition on role functioning). Health-related goals typically involve knowledge acquisition, identifying and obtaining necessary resources, developing and programming critical skills, and building self-efficacy.

For example, if a participant had a goal of, “I want to establish a sustainable fitness and exercise routine,” the PROS program could:

- explore and address the mental health barriers related to the goal (e.g., depressive symptoms that make it difficult to find motivation or anxiety symptoms that prevent them from leaving the house),
- identify different types of exercise and find what the person enjoys,
- find and try out gyms and other fitness-related settings in their community,
- assist the participant with getting a gym membership and financial assistance (if needed), and
- support the participant with putting in place compensatory supports needed to be successful in the chosen setting (e.g., downloading a motivational app on their phone, setting reminders on their calendar, finding an accountability partner, creating an exercise journal, etc.).

In this example, the PROS program is *not* serving as or replacing the fitness center or providing fitness training, but instead supporting the participant with obtaining the skills and supports they will need to be independent with obtaining and sustaining their goal long-term.

TOBACCO AND NICOTINE

According to the CDC, smoking is the leading cause of preventable disease, disability, and death in the United States (2022). Individuals with serious mental illness (SMI) die on average 25 years younger than individuals without mental illness in large part due to cardiovascular and pulmonary disease caused by use of cigarettes. When we look at mental illness and tobacco use disorder (TUD) comorbidity, research has found:

- Individuals with mental illness account for 25% of the adult population, but consume almost 40% of cigarettes sold in the U.S.
- Individuals with SMI tend to be heavier smokers *and* extract more nicotine for each cigarette they smoke.

- While smoking rates among the general population have fallen dramatically since the 1960s, very little progress has been made among those with SMI.

(Schroeder, 2016)

In addition to the well-known and researched health impact of tobacco use, it is important for PROS programs to explore the ways in which tobacco use may be a barrier to recovery and community participation. Smoking carries a social stigma that often results in society- and self-imposed segregation. Individuals who smoke may experience their addiction as a barrier to employment, educational attainment, socialization, and even housing. While the use of electronic cigarettes, or vaping, may be less stigmatized, it is not without health risks.

HOW PROS CAN SUPPORT TOBACCO-RELATED GOALS AND OBJECTIVES

Participants may have specific tobacco-related goals, like "I want to quit smoking," or "I want to reduce the amount that I smoke," but often addressing tobacco use is an objective related to their recovery goal. For example, if tobacco use is source of stress in their relationship, their goal may be to improve their relationship while an objective is to reduce tobacco use. Below are some examples of how different components and services may be used to support participants with tobacco related goals, objectives, and barriers:

- CRS – Psychosocial Rehabilitation is an excellent service for participants who use tobacco and are in the pre-contemplation or contemplation stages of change. For example, wellness self-management approaches can be used to provide accurate information, raise consciousness, and explore the relationship between tobacco use and mental health symptoms – or tobacco use and other life difficulties. This service can also be used to teach mindfulness-based strategies that can increase the participant's awareness of their environment, thoughts, emotions, and physical sensations related to tobacco use, cravings, and withdrawal. Programs may choose to run entire groups/classes focused on tobacco education and mental health, they could weave tobacco information throughout wellness-related groups, or they could do both.
- IR – Integrated Treatment for Co-Occurring Disorders is used to provide intensive support to participants who are ready to accept services related to their tobacco use (planning/preparation, active, and maintenance stages of change). The PROS Integrated Treatment service employs a harm-reduction model to addiction, and participants are not expected to *quit* or *abstain* from tobacco use altogether unless that is their choice.
- CT – Clinical Counseling and Therapy can be used to provide cognitive behavioral therapy, including cognitive restructuring interventions, which is one of the most well-established verbal therapies for treatment of tobacco use disorder.

PROS WITH CLINICAL TREATMENT: EVIDENCE-BASED PHARMACOLOGICAL TREATMENT FOR TUD

It should be noted that the symptoms of nicotine withdrawal are often confused with an exacerbation of mental health symptoms. When an individual stops using nicotine, they are likely to experience irritability and frustration, anxiety, difficulty concentrating, restlessness and impatience, depressed mood, insomnia, increased appetite and weight gain, and cravings. These unpleasant side effects can lead to a withdrawal-use-relief loop, wherein the individual's mental health status and symptoms improve when they use nicotine again.

- *Varenicline (Chantix)* is an FDA-approved medication for treatment of TUD. It is very effective in helping individuals reduce or stop using cigarettes or e-cigarettes and should be considered as a first-

line treatment even if the individual is in a pre-contemplative stage and does not wish to engage in any kind of therapy or rehabilitation. Varenicline temporarily had a black box warning over concerns that it resulted in a worsening of psychiatric symptoms, but this has been determined not to be true and the FDA has removed the black box warning.

- *Nicotine replacement therapy (NRT)* can help manage these side effects and improve quality of life, even for those who only want to reduce their tobacco use and may not be ready to quit altogether. The best way to use NRT is to offer clients a long-acting form, such as the patch, and a short acting form, such as the gum, lozenge, inhaler, or nasal spray. Combined NRT has the best evidence for decreased use or remission. It is not necessary to limit the duration of NRT treatment. Individuals who use e-cigarettes may need higher doses of NRT.

COVID-19, FLU, AND RESPIRATORY VIRUSES

In-person, group-based services are an excellent way to foster intentional community. However, the COVID-19 pandemic has highlighted the critical importance of prioritizing safety considerations and implementing measures to reduce the risk of respiratory virus transmission.

COVID-19 Infection Control Manual for Public Mental Health System Programs outlines several safety measures utilized to reduce COVID-19 transmission. Measures such as implementing social distancing protocols, encouraging the use of masks, ensuring proper ventilation in program spaces, and providing hand sanitizer stations throughout the area, may be helpful in reducing the transmission of other viruses.

WORKING WITH HEALTH HOMES

It is important to remember that while the CRS – Complex Care Management service opens up important avenues for PROS programs to coordinate care on an urgent basis, it is *not* routine care coordination. When a participant has the need for ongoing care coordination services, PROS programs should consider whether Health Home Care Management/ Health Home Plus may be an appropriate referral to make.

Care managers often play an important role in the overall coordination of services for the PROS participant. Collaboration with care management providers should be a regular and routine practice to ensure continuity of care and linkage to necessary services and benefits.

PART 11: SUPPORTING EMPLOYMENT AND EDUCATION GOALS

EMPLOYMENT AND EDUCATION STATUS AS SOCIAL DETERMINANTS OF HEALTH AND MENTAL HEALTH

Employment status, education level, and socioeconomic status are key social determinants of health and mental health. As such, PROS programs focus on competitive, integrated employment and educational attainment as primary outcomes, with an emphasis on evidence-based practices as tools for helping participants complete their education and obtain competitive, integrated employment.

PROS EMPLOYMENT INITIATIVE

The PROS Employment Initiative (previously called the PROS Vocational Initiative) provides state aid funding to offset the provision of employment services that are not eligible for Medicaid reimbursement, such as job development and job coaching. Enhanced funding was added in 2022 to support full implementation of the IPS model.

PROS EMPLOYMENT INITIATIVE FUNDING

The PROS Employment Initiative is funded through state aid (net deficit funding). In New York City, programs receive these funds through a direct contract with OMH. In Western New York, Central New York, Hudson River, and Long Island, programs receive these funds through their local government unit, or county (via a contract with the county). The exact funding amount that any program receives is tied to their average census, and this amount is rebased annually to account for changes in their census.

This funding is used for a variety of purposes to support employment services in PROS, including but not limited to:

- Competitive salary and fringe for at least 1.0 FTE well-qualified Employment Specialist(s) per PROS program,
- Staff time and agency resources needed for participation in IPS training and the Center for Practice Innovation's IPS Learning Collaborative,
- Staff transportation costs related to off-site employment and education activities,
- Employment and educational services under the IPS model that are not covered by Medicaid, including job development and short-term job coaching, and
- New York Employment Services System (NYESS) training and implementation.

Note: This state aid funding may not be used for any costs unrelated to the provision of supported employment. This includes capital expenditures, program fees, and wages for PROS participants.

IPS AND MEDICAID REIMBURSEMENT

PROS is authorized under the federal Rehabilitative Services Option, which funds services such as counseling, psychosocial rehabilitation, and other therapeutic interventions, which may have a secondary benefit of enabling participants to obtain or maintain integrated, competitive employment opportunities. For example, PROS programs deliver services that assist participants to restore functioning, manage stress, and cope with symptoms – all of which can support goals related to obtaining and maintaining employment.

IPS includes services and activities that are eligible for Medicaid reimbursement as well as services that are not eligible for Medicaid reimbursement. Employment services and attaining competitive employment are integral parts of the recovery focus of PROS. It is the expectation that each PROS will offer IPS as an ongoing part of the PROS program. Whether IPS interventions are eligible for Medicaid reimbursement should have no bearing on the frequency and consistency of opportunities available to PROS participants to participate in IPS vocational services.

IPS practices are considered eligible for Medicaid reimbursement when the interventions are focused on helping the participant overcome a mental health barrier that prevents the participant from attaining their goal of becoming or remaining employed. In such cases, IPS practices implemented through a Medicaid-billable service must be medically necessary rehabilitative services.

Program costs to implement IPS practices that are not reimbursable under Medicaid are offset by net deficit funding under the PROS Employment Initiative (Program Code 8350).

See Appendix E for more information on IPS and Medicaid Reimbursement, including examples of how PROS services can be used to deliver IPS.

CPI LEARNING COLLABORATIVE & IPS FIDELITY

The Center for Practice Innovations (CPI) offers training and support to PROS programs in the IPS approach to supported employment via the IPS Learning Collaborative. All PROS programs must be enrolled in the Learning Collaborative. Additional information is included in the Staff Training & Competencies Guidance.

Higher-fidelity implementation of IPS is associated with improved outcomes for program participants. CPI trains PROS staff in completing fidelity self-assessments, and PROS programs conduct annual (once per year) self-assessments using the IPS Fidelity Scale. This tool can be used to support continuous quality improvement. Results of the IPS Fidelity Scale should be made available to OMH upon request.

On some items, PROS programs may not be able to achieve the highest level of fidelity. For example, smaller programs would likely not employ a vocational unit including multiple staff. Technical assistance related to use of the IPS Fidelity Scale is available through CPI.

EMPLOYMENT INITIATIVE DELIVERABLES AND & REPORTING REQUIREMENTS

PROS programs are required to meet the below deliverables related to their Employment Initiative state aid funding:

1. Each PROS program must employ at least one FTE Employment Specialist. Programs with more than 100 individuals enrolled in CAIRS must prorate an additional Employment Specialist FTE per each 100 individuals enrolled.
2. All PROS staff must receive training in IPS. Documentation of such training will be maintained in human resources records. CPI offers a free online module on IPS via their online learning management system, which would meet this requirement. This deliverable will be met when 80% of program staff, who have been employed in PROS for at least 6-months, have completed training in IPS.
3. All participant case records must include a Comprehensive Psychiatric Rehabilitation Assessment, including an assessment of the individual's employment goals and needs.

4. All participants who express interest in employment must be entered into the New York State Employment Services System (NYESS), and relevant information must be maintained as required.
5. Programs must comply with the below reporting requirements:
    a. Employment Specialist Vacancies: Vacancies in the Employment Specialist position(s) must be reported to OMH through the Employment Specialist Vacancy Report. This report is submitted electronically and includes: the date the vacancy began, a description of hiring/recruitment efforts, and a description of how employment-related services will be provided in the interim for participants with employment goals.
    b. CAIRS Admission, Follow-ups, and Discharges: Each participant's employment status is to be entered at admission, with every 6-month follow-up, and at discharge.

PART 12: PROS-PROGRAM SPECIFIC REPORTING SYSTEMS & REQUIREMENTS

CHILD AND ADULT INTEGRATED REPORTING SYSTEM (CAIRS)

CAIRS for PROS is a secure registration and reporting system for recipient-level data. PROS programs use CAIRS for:

- Submitting participant registrations in PROS (required for admission),
- Connecting to the ePACES/eMedNY interface that permits processing of Medicaid claims, and
- Entering demographic and outcome data for participants to support program evaluation and monitoring.

REGISTRATION AND DEMOGRAPHIC DATA

Upon admission, the individual must be registered in CAIRS for each component they will be participating in.

Note: You can change component registration if a participant decides to add or remove one of the components. When this occurs, the program must update the participant's registration in CAIRS.

Demographic and identifying data must be entered as accurately as possible, including the participant's full name, date of birth, Medicaid CIN (if applicable), and Social Security Number (if known). This information is used to connect to the ePACES/eMedNY interface that permits processing of Medicaid claims and feeds OMH data.

When an individual is admitted in CAIRS, OMH will apply Recipient Restriction Exception (RRE) codes to their Medicaid file. These RRE codes will help prevent duplicative program types from receiving payment for services. For more information on RRE codes, please see the PROS Billing & Claiming Manual.

FOLLOW-UPS AND DISCHARGES

Follow-up reporting is required every 6 months for the duration of a participant's enrollment in PROS. Follow-up reports include entering any updates or changes to their employment, educational, or housing status. These reports are used to monitor the program's performance overall. Programs may wish to align follow-up reporting with IRP reviews in order to streamline how and when progress is monitored.

Discharges must be entered in CAIRS as soon as possible upon a participant's discharge from PROS. Programs must accurately reflect the date of discharge in CAIRS as the last date of service. Failure to discharge participants in a timely manner can impact their ability to receive services elsewhere, as the RRE codes will not be removed from their Medicaid file until the discharge is entered.

NEW YORK EMPLOYMENT SERVICES SYSTEM (NYESS)

NYESS is a web-based case management tool that is used by PROS programs and other employment services providers across the state. NYESS facilitates collaboration between participating NYS agencies to help participants find and keep jobs and will also enable agencies to participate in the Social Security Administration (SSA)'s Ticket to Work initiative more effectively. Agencies partnering in NYESS include the NYS OMH, Department of Labor (DOL), Office of Addiction Services and Supports (OASAS), Commission for the Blind and Visually Handicapped (CBVH), Office for the Aging (OFA), and Office for People with Developmental Disabilities (OPWDD).

NYESS provides Employment Specialists with a useful tool in providing vocational services to participants and can be an important resource in job development. Staff providing IPS services can use NYESS to work with people individually to provide job-related supports, including benefits management, resume-building, Ticket to Work, and accessing tax credits. NYESS will enhance and expand the individualized services that the Employment Specialist is able to provide to the people on their caseload.

NYESS REPORTING REQUIREMENTS

Each participant who expresses an interest in employment must be entered in NYESS, which includes at minimum:

- Active NYESS record
- All employment and related activities (billable and non-billable) are entered via the Activities Module
- All employment experiences, including volunteer, work-based learning, and standard job placements, must be entered in the Jobs Info tab.

NYESS offers regular trainings and technical assistance regarding data entry and how to use the systems. For more information, please contact the NYESS team.

OTHER OMH DATABASES

PROS staff and administrators will need to access OMH systems, including the Mental Health Provider Data Exchange (MHPD), New York State Incident Management and Reporting System (NIMRS), and the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). For more information on accessing these databases, please see the OMH PROS Website.

PART 13: LICENSING

THE OPERATING CERTIFICATE

PROS programs must maintain an operating certificate, which indicates whether the program is licensed with or without the Clinical Treatment component. For more details, see Part 512.5. The program must have the operating certificate displayed in a common area.

Requested changes to the Operating Certificate, such as the program type operated (with or without Clinic Treatment), location, hours of operation, or monthly caseload, can be coordinated with respective OMH Field Offices.

HOURS OF OPERATION

Changes to a program's hours of operation are subject to approval by OMH in consultation with the local government unit (LGU). PROS programs may, on occasion, deliver non-routine services outside the hours of their operating certificate (e.g., Crisis Intervention). In the event participants are regularly requesting services outside of the program's operating hours, the program should evaluate whether a change in hours is necessary and sustainable. If participants are routinely requesting services outside of the programs operating hours, the program may request to include "additional hours by appointment" to their hours of operation.

CASELOAD AND CENSUS

The monthly caseload is the total number of people to whom a PROS program can provide services in a given month, as indicated on the operating certificate.

A program's census is the actual number of participants currently enrolled in any component of the program. The census is based on CAIRS registration.

Programs may request an increase or reduction in their monthly caseload through an Administrative Action or E-Z PAR in accordance with Part 551. As part of this process, OMH will take into consideration factors related to the sustainability of the change, including but not limited to:

- number of individuals currently served,
- modalities provided,
- physical space and number of group rooms/ classrooms,
- current staffing plan, and
- current program schedule.

ADDING IR - COGNITIVE REMEDIATION

Cognitive Remediation is an optional PROS service, subject to prior review and written approval by OMH through an Administrative Action process. PROS programs will only be approved to deliver this service if they meet the following requirements:

- Staff have completed an approved evidence-based or evidence-informed training program in Cognitive Remediation, and
- The program demonstrates a capacity to deliver the service (e.g., has relevant software licenses, computers, and internet connection available).

For a complete list of approved training programs, or if your agency has identified a Cognitive Remediation training program that has not yet been approved, please contact the Rehabilitation Services and Treatment Unit at OMH Central Office.

TELEHEALTH SERVICES

Telehealth Services Guidance for OMH Providers includes specific provisions related to the delivery of telehealth services in PROS. Programs approved to deliver services via telehealth must comply with this guidance and any future updates.

THE PROS STANDARDS OF CARE (SOC)

The PROS SOC is utilized to determine effective and appropriate delivery of PROS services.

OMH recommends that agencies operating PROS programs complete a PROS SOC Agency Self-Assessment and submit an effective quality improvement plan prior to certification visits. The Self-Assessment tool is posted on the OMH PROS website.

APPENDIX A: GLOSSARY

The following words and terms, when used in this document, shall have the following meanings, unless the context clearly indicates otherwise. Additional terms are defined in Part 512.4.

Admission date: The day that the PROS program successfully completes and submits a PROS registration form on behalf of a PROS participant, using the registration system approved by the office, CAIRS.

Census: The number of individuals currently served by a given outpatient program. In PROS, this number is based on the CAIRS roster.

Collateral: Includes the participant's family, family of choice, and others significant in their life or integral to their PROS goal, who provide a direct benefit to the participant. Services may be delivered to a collateral in accordance with the participant's IRP, and for the purpose of advancing their goals and for coordination of services with other community behavioral health and medical providers.

Competent mental health professional: Professional Staff and Certified Peer Specialists or Credentialed Youth Peer Advocates with at least three years of direct experience providing peer support services.

Competitive, integrated employment: The term "competitive, integrated employment" means work that:

- is performed on a full-time or part-time basis, including self-employment, for which an individual is compensated at a rate that shall be not less than minimum wage;
- is reimbursed at no less than the customary rate paid by the employer for the same or similar work performed by other employees who are not individuals with disabilities, and who are similarly situated in similar occupations by the same employer and who have similar training, experience, and skills;
- in the case of an individual who is self-employed, yields an income that is comparable to the income received by other individuals who are not individuals with disabilities, and who are self-employed in similar occupations or on similar tasks and who have similar training, experience, and skills;
- is eligible for the level of benefits provided to other employees;
- takes place in an environment where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons; and
- presents opportunities for advancement that are similar to those for other employees who are not individuals with disabilities and who have similar positions, as appropriate.

Note that seasonal temporary jobs, jobs through temporary agencies that are open to other community members, and positions through Javits-Wagner-O'Day (JWOD) and New York Industries for the Disabled (NYSID) are considered competitive, integrated employment.

Designated mental illness diagnosis: A Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis or International Classification of Diseases (ICD) equivalent other than:

- substance-related and addictive disorders in the absence of other mental health conditions defined in the DSM or ICD;
- neurodevelopmental disorders in the absence of other mental health conditions defined in the DSM or ICD, except Attention-Deficit/Hyperactivity Disorder and Tic Disorders;

- neurocognitive disorders, including traumatic brain injury, or mental disorders due to another medical condition; or
- V-Codes. Other conditions that may be a focus of clinical attention (commonly described with Z codes).

Direct supervision: The appropriate professional staff must be available at all times to furnish assistance and direction to paraprofessional staff for the purpose of addressing issues in the provision of any PROS service component. This does not require that the supervisor be present in the room at the time the service is rendered.

Functional disability: A deficit caused by the designated mental illness that rises to the level of impairment in one or more major life activities, such as:

- Activities of daily living (ADLs): eating, dressing, bathing, grooming, etc.
- Instrumental activities of daily living (IADLS): managing finance, cooking and meal preparation, managing medications, attending appointments, navigating community, etc.
- Participating in family, school, or workplace: establishing and maintaining positive interpersonal relationships and interactions, managing mental health symptoms in different environments or settings, emotional regulation, self-advocacy, etc.

Intervention**:** The activities and services provided by PROS staff that help the participant achieve objectives and goals.

Local Governmental Unit (LGU): The unit of government given the authority in accordance with article 41 of the Mental Hygiene Law to plan and provide for local or unified services.

Monthly caseload**:** The maximum number of individuals who can be registered to receive services from the PROS program in any given month.

New York Employment Support System (NYESS)**:** A secure, computer-based case management tool developed by OMH and NYS Department of Labor used by PROS providers to provide employment services and as a data-reporting instrument.

Objective**:** Something the participant will do or accomplish as a step toward achievement of the goal. Objectives should address identified barriers to the goal and should drive the IRP forward. Objectives should answer the questions: How will you achieve that? What steps will you take? When will you take them? Who will help you?

Off-site: For purposes of providing PROS services, means any clinically appropriate location in the community, other than a licensed PROS site, where an individual may receive services. For the purposes of billing and claiming, off-site does not include any space that is co-located at the same address as the PROS program.

Onsite**:** The program's licensed space.

Person-Centered Planning: An individual participates to every extent possible, in the planning of their services and empowers the individual to make choices about the services and supports that they receive.

Personal wellness plan**:** An individualized tool that supports participants in understanding their individual factors which may trigger a recurrence of severe mental health symptoms and identifies ways to cope with the

potential for recurrence. It includes a description of the participant's preferences regarding treatment and any PROS services that may be used in the event of a crisis.

Pre-admission status: The time period that begins when an individual first receives a PROS pre-admission service and ends on the individual's PROS admission date.

Policy and procedure**:** *Policy* describes a guideline or plan for addressing a specific issue, concern, or topic. *Procedure* describes the process that staff, managers, and the organization will follow in accordance with the policy. Procedures typically include who is responsible for different tasks and the steps needed to accomplish the task. Effective policies and procedures support high quality service delivery and compliance with State and Federal policies and regulations.

PROS goal**:** A statement that expresses the participant's desire for positive change and improvement in their lives, ideally captured in their own words. Goals answer the basic question: What do you want?

Recipient employee: An individual who is financially compensated by a provider for providing PROS services in the same program where the individual also receives PROS services.

Recovery Vision**:** A statement that expresses the participant's long-term desire for positive change and improvement in their lives, ideally captured in their own words.

Registration: The process by which individuals are assigned to PROS programs and specific PROS components through CAIRS. The programs with which individuals are registered are recognized by the office as authorized providers of PROS services for those individuals.

Shared decision making**:** A process whereby practitioner and participant work together to select treatments and services based on both the participant's preferences and clinical evidence. See also "Person-Centered Planning."

APPENDIX B: STAFF QUALIFICATIONS

PARAPROFESSIONAL STAFF

Paraprofessional staff include the following:

- *Certified Peers:* Individuals who have are certified or credentialed by the New York Peer Specialist Certification Board (NYPSCB) as a Certified Peer Specialist (CPS), including those with provisional certification (CPS-P), and individuals who have been credentialed by the Families Together in New York State as a Youth Peer Advocate (YPA-C), including those with provisional credentials (YPA-PC) and are supervised by a competent mental health professionals, including Professional Staff or by a CPS or YPA-C with three years of experience providing direct peer support services.
- *Licensed Practical Nurses (LPN):* Individuals who are currently licensed or permitted as an LPN by the NYS Education Department.
- *Other individuals* who are at least 18 years old, possess at least a high school diploma or high school equivalency certificate, and demonstrate six (6) months professional and/or personal experience in a mental health or human services field.

Paraprofessional staff must be supervised by Professional staff, unless otherwise indicated based on the type of service they are delivering. For example, LPNs may be supervised by any Professional Staff in the delivery of CRS – Psychosocial Rehabilitation, but they must be supervised by under the supervision of a registered professional nurse, licensed physician, or physician assistant in the delivery of CT – Health Assessment within their scope of practice. Similarly, Certified Peers may be supervised by any Professional Staff in the delivery of CRS – Psychosocial Rehabilitation, but they may be supervised by a competent mental health professional in the delivery of CRS – Peer Support Services.

STUDENT INTERNS

Student Interns are individuals who are participating in a supervised educational program at an institution approved by the State Education Department leading to a degree and eligibility for NYS licensure or certification under one of the following professions:

- Creative Arts Therapist,
- Psychoanalyst,
- Psychologist,
- Marriage and Family Therapist,
- Mental Health Counselor,
- Occupational Therapy,
- Nurse Practitioner,
- Nurse Practitioner in Psychiatry,
- Physician,
- Physician Assistant,
- Psychiatrist,
- Registered Professional Nurse, and
- Social Worker.

PROFESSIONAL STAFF

Professional staff: Individuals who are qualified by credentials, training, and experience to provide supervision and direct service related to the care or treatment of persons with a designated mental illness diagnosis, and includes the following:

- *Certified Psychiatric Rehabilitation Practitioner:* An individual who is currently certified as a psychiatric rehabilitation practitioner by the Psychiatric Rehabilitation Association.
- *Creative Arts Therapist:* An individual who is currently licensed or has a limited permit to practice as a creative arts therapist by the NYS Education Department, or who has a master's degree in a mental health field from a program approved by the NYS Education Department, and registration or certification by the American Art Therapy Association, American Dance Therapy Association, National Association of Music Therapy or American Association for Music Therapy.
- *Credentialed Alcoholism and Substance Abuse Counselor:* An individual who is currently credentialed by the NYS Office of Addiction Services and Supports in accordance with Part 853 of Title 14 of the NYCRR.
- *Marriage and Family Therapist:* An individual who is currently licensed or has a limited permit as a marriage and family therapist by the NYS Education Department.
- *Mental Health Counselor:* An individual who is currently licensed or has a limited permit to practice as a mental health counselor by the NYS Education Department.
- *Nurse Practitioner:* An individual who is currently certified or has a limited permit to practice as a nurse practitioner by the NYS Education Department.
- *Nurse Practitioner in Psychiatry:* An individual who is currently certified as a nurse practitioner in psychiatry by the NYS Education Department. For purposes of this manual, nurse practitioner in psychiatry will have the same meaning as psychiatric nurse practitioner, as defined by the NYS Education Department.
- *Occupational Therapist:* An individual who is currently licensed as an occupational therapist or has a limited permit to practice by the NYS Education Department.
- *Pastoral Counselor:* An individual who has a master's degree or equivalent in pastoral counseling or is a Fellow of the American Association of Pastoral Counselors.
- *Physician,* which means an individual who is currently licensed or has a limited permit to practice as a physician by the NYS Education Department.
- *Physician Assistant:* An individual who is currently registered or has a limited permit to practice as a physician assistant or a specialist's assistant by the NYS Education Department.
- *Psychiatrist:* An individual who is currently licensed or has a limited permit to practice as a physician by the NYS Education Department and who is certified by, or eligible to be certified by, the American Board of Psychiatry and Neurology.
- *Psychoanalyst:* An individual who is currently licensed or has a limited permit to practice as a psychoanalyst by the NYS Education Department.
- *Psychologist:* An individual who is currently licensed or has a limited permit to practice as a psychologist by the NYS Education Department. Individuals with at least a master's degree in psychology who do not meet this definition may not be considered licensed practitioners of the healing arts and may not be assigned supervisory responsibility. However, individuals who have obtained at least a master's degree in psychology may be considered professional staff for the purposes of calculating professional staff and full time equivalent professional staff.

- *Registered Professional Nurse:* An individual who is currently licensed or has a limited permit to practice as a registered professional nurse by the NYS Education Department.
- *Rehabilitation Counselor:* An individual who has either a master's degree in rehabilitation counseling from a program approved by the NYS Education Department or current certification by the Commission on Rehabilitation Counselor Certification.
- *Social Worker*: An individual who is currently licensed or has a limited permit to practice as a master social worker (LMSW) or clinical social worker (LCSW) by the NYS Education Department. LMSWs must be supervised by a LCSW, licensed psychologist, or psychiatrist employed by the agency.
- *Therapeutic Recreation Specialist:* An individual who has either a master's degree in therapeutic recreation from a program approved by the NYS Education Department or registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society.

COMPETENT MENTAL HEALTH PROFESSIONAL

Competent mental health professionals include:

- Professional Staff (as defined above)
- Certified Peer Specialists or Credentialed Youth Peer Advocates with at least three years of direct experience providing peer support services

LICENSED PRACTITIONER OF THE HEALING ARTS

Licensed Practitioner of the Healing Arts (LPHA) are practitioners who have the ability and appropriate state licensure to independently make a clinical assessment, certify a diagnosis and recommend treatment for individuals with a mental illness. All LPHAs are considered Professional Staff and count towards those specific staffing requirements, but not all Professional Staff are LPHAs. The following are considered LPHAs in PROS programs:

- Nurse Practitioner
- Physician
- Physician Assistant
- Nurse Practitioner in Psychiatry
- Psychiatrist
- Psychologist
- Registered Professional Nurse
- Licensed Mental Health Counselor
- Licensed Clinical Social Worker (LCSW)
- Licensed Master Social Worker, under the supervision of a LCSW, licensed psychologist, or psychiatrist employed by the agency
- Licensed Creative Arts Therapist
- Licensed Occupational Therapist
- Licensed Marriage and Family Therapist
- Licensed Psychoanalyst

STAFF QUALIFICATIONS TABLE

Table 4 is intended to briefly illustrate the qualifications for paraprofessionals, professionals, and LPHAs. Please see above for full details and definitions of each profession.

Table 4 PROS Staff Qualifications

Paraprofessional	Professional	LPHA
Paraprofessional staff include the following: • *Certified Peers* • *Licensed Practical Nurses (LPN)* • *Other Individuals* who are at least 18 years old, possess at least a high school diploma or high school equivalency certificate, and demonstrate six (6) months professional and/or personal experience in a mental health or human services field	• Certified Psychiatric Rehabilitation Practitioner • Credentialed Alcoholism and Substance Use Counselor • Licensed Clinical Social Worker (LCSW) • Licensed Creative Arts Therapist (LCAT & CAT-LP) • Licensed Marriage and Family Therapist (LMFT & MFT-LP) • Licensed Master Social Worker • Licensed Mental Health Counselor (LMHC & MHC-LP) • Licensed Psychoanalyst • Nurse Practitioner • Nurse Practitioner in Psychiatry • Licensed Occupational Therapist • Pastoral Counselor • Physician Assistant • Physician (MD or DO) • Psychiatrist • Psychoanalyst • Psychologist • Registered Professional Nurse • Rehabilitation Counselor • Therapeutic Recreation Specialist	• Licensed Creative Arts Therapist (LCAT) • Licensed Marriage and Family Therapist (LMFT) • Licensed Clinical Social Worker (LCSW) • Licensed Master Social Worker, under the supervision of a LCSW, licensed psychologist, or psychiatrist employed by the agency • Licensed Mental Health Counselor (LMHC) • Licensed Psychoanalyst • Nurse Practitioner • Nurse Practitioner in Psychiatry • Licensed Occupational Therapist • Physician Assistant • Physician • Psychiatrist • Psychologist • Registered Professional Nurse

APPENDIX C: PSYCHOSOCIAL REHABILITATION

The PROS Psychosocial Rehabilitation (PSR) service is broad and encompasses multiple types of skill development, skill programming, resource development, and resource programming. The below descriptions of interventions are intended to illustrate the breadth of the PSR service. PSR is not limited to these categories.

The CRS – Psychosocial Rehabilitation service includes but is not limited to:

- *Basic Living Skills Training (BLST)* is an intervention designed to improve a participant's ability to perform the basic skills necessary to achieve maximum independence and acceptable community behaviors that are critical to their recovery. This intervention focuses on the acquisition of skills, as well as strategies for appropriate use of the skill, utilizing teaching interventions including but not limited to motivational, educational and cognitive-behavioral techniques. BLST may include opportunities to practice, observe, reinforce and improve the participant's skill performance. The topics which may be covered, include but are not limited to, grooming and personal hygiene, nutrition, homemaking, building relationships, childcare, transportation, use of community resources, and engaging in social interactions.

- *Benefits and Financial Management (BFM)* is an intervention designed to support a participant's functioning in the community through understanding and skill in handling their financial resources. The instruction may include counseling on budgeting, income and benefits, including incentives for returning to work as well as basic counseling on income maintenance, eligibility for benefits from relevant sources, and determination of the need for plans for additional support and assistance in managing personal finances. BFM may also assisting participants in reacquiring skills and capabilities that were lost as a result of the onset of mental illness and that are necessary to manage their own finances.

- *Community Living Exploration (CLE)* is an intervention designed to help a participant understand the demands of specific community life roles in order to make decisions regarding participation in those roles. CLE can also be used to help motivate participants who are not yet exhibiting active interest in more integrated community life roles by increasing their knowledge of opportunities available in the community. Topics may include but are not limited to options for satisfactory experiences with living environments, work or career opportunities, educational opportunities, opportunities to connect to culturally based community services, and resources for use of leisure time. It is expected that, to the extent possible, these services will be delivered in natural community environments.

- *Engagement in Recovery* is an intervention designed to motivate and support participants receiving PROS to participate in the rehabilitation and recovery process. This includes fostering therapeutic relationships supportive of the participant’s recovery.

- *Skill Building for Self-Help (SBSH)* is an intervention designed to help participants restore the skills necessary to identify and participate in or take advantage of appropriate self-help resources or mutual aid groups. The intervention is designed to help a participant understand what self-help resources are available in the community and how to benefit from participating in them. SBSH may be conducted by people who have common experiences and is intended to help the participant to learn how to share personal experiences, to learn about the variety of available self-help groups, and to aid the participant in accessing the self-help options of their choice.

- *Structured Skill Development and Support (SSDS)* is designed to assist participants to regain the skills necessary for performing normative life roles associated with group membership, work, education, parenting, or living environments by modeling and practicing skills in actual community settings off-site or community environments replicated at the program site and through the use of structured activities. Skills are developed through a structured process of teaching, practice, observation and feedback. Using this approach, direct contact between the participant and the practitioner is intermittent: at the beginning to clarify tasks and skills being addressed, during the service to monitor and provide feedback at various intervals, and at the end to debrief with the participant.

- *Wellness Self-Management (WSM)* is an intervention designed to develop or improve personal coping strategies, prevent relapse, and promote recovery. WSM includes but is not limited to:

    - *Coping Skills Training:* Teaching participants strategies to address symptoms, manage stress and reduce exposure and vulnerability to stress.

    - *Disability Education:* Instruction on the facts concerning mental illness and the potential for recovery. The intent of this service is to give participants admitted to PROS programs and collaterals hope as well as practical information on prevention and recovery practices, including evidence-based practices.

    - *Co-occurring Disorder Education:* Providing participants admitted to PROS programs and/or collaterals with basic information on the nature of addiction and substance use disorders and how they relate to the symptoms and experiences of mental illness.

    - *Medication Education and Self-Management:* Providing participants admitted to PROS programs or collaterals with information on the participant's medications, including related efficacy, side effects and compliance issues. Participants are supported in managing their medications, learning about the effects of the medication on their mental health condition, and managing the side effects of medication through healthy lifestyle changes, such as smoking cessation, nutrition, and weight loss.

    - *Problem-Solving Skills Training:* A series of learning activities designed to assist participants admitted to PROS programs and collaterals develop effective solutions for stressful responses to routine life situations. These activities may include, but are not limited to, role playing exercises, homework assignments or the mastery of specific principles and techniques.

    - *Relapse Prevention Planning:* A process to engage participants admitted to PROS programs and collaterals in understanding factors which may trigger a recurrence of severe symptoms of mental illness and ways to cope with the potential for recurrence. Planning activities may include the development of an advance directives document and specific instructions on what steps need to be taken in the event of a relapse.

APPENDIX D: DOCUMENTATION EXAMPLES

INDIVIDUALIZED RECOVERY PLAN: EXAMPLES OF REQUIRED ELEMENTS

Table 5 is intended to illustrate of the *type* of information that might be recorded under each required element in the IRP.

Table 5 IRP Examples of Required Elements

Required Element	Examples
a) The participant's name, including preferred name, when applicable	• Legal Name • Nickname • Preferred Name
b) Recovery vision and PROS goal(s)	
c) Objectives that are measurable, have target dates, and clearly represent steps toward the achievement of the participant's service goal(s)	
d) Criteria to determine when goals and objectives have been met so that the participant can move forward in their recovery process	
e) Strengths	• Skills • Talents / Abilities • Personal Characteristics or Attributes
f) Supports and resources	• Family and family of choice • Access to technology, internet, phone • Housing • Access to transportation (car, public transportation, friends/ relatives, etc.) • Colleagues, peers, neighbors • Benefits and entitlements (SNAP, Section 8, SSI/SSDI, etc.) • Connection to ACCES-VR, BOCES, EOC, local universities or colleges • Bank or credit union (checking account)
g) Mental health barriers and needs	• Current/most pressing mental health symptoms impacting functioning and quality of life • Risk factors identified through the assessment and screening process • Traumatic experiences or stressors impacting program participation or goal acquisition • Readiness and motivation
h) Other barriers and needs as it relates to goal attainment (e.g., environmental, medical, or legal barriers)	• Environmental issues like transportation • Medical conditions that limit activity • Childcare and other caregiving responsibilities • Legal issues
i) Specific PROS services to be provided, including type and frequency	

Required Element	Examples
j) The identification of any collaterals who will assist the participant in their recovery	• Health Care Proxy • Parent/ Stepparent • Siblings • Adult children • Friends and family of choice • Extended family • Care Manager • Residential staff • Psychiatrist or other outside clinician • Primary Care Provider • Medical Specialists • Landlord • Employer • Faith Leader • Academic Counselor • Vocational Rehabilitation Counselor • Social Services/ Protective Services caseworker
k) An indication of whether the participant has any advanced directives, and if so, where they can be found in the event of an emergency or crisis	• Psychiatric Advanced Directives (formal) • Living Will • MOLST (DNR) (for participants with chronic physical health conditions) • Wellness action plan or relapse prevention plan
l) Name, title, and credentials/qualifications of the staff member developing the IRP	
m) Staff and participant signatures	

MONTHLY SUMMARY NOTE: EXAMPLES OF REQUIRED ELEMENTS

Table 6 is intended to illustrate of the *type* of information that might be recorded under each required element in the MSN:

Table 6 MSN Examples of Required Elements

Required Element	Examples
a) The timeframe (start and end dates) covered by the note	
b) A brief description of the participant's engagement and participation in PROS	• Describe their attendance, including any issues related to absences, if applicable • Engagement level in group-based services or any concerns related to their behavior in groups • Note whether they participate in recovery-oriented activities in PROS • Concerns or issues related to telehealth-based services, including connection issues that impact participation

Required Element	Examples
c) A summary of the progress made towards objectives identified in the IRP subsequent to the previous monthly summary note. If the participant has not made progress, or has regressed, this should also be noted. Whenever possible, this section of the note should include the participant's perspective on their progress or lack thereof.	• Positive behavioral changes the participant has made or sustained • Any new skills they attempted, practiced, or mastered • Connection to or accessing new resources and supports • Their level of independence in performing new skills • Any differences observed or reported in skill performance across different settings or environments • Any successes shared by the participant or observed by staff • Tasks or skills the participant is struggling to learn, apply, and/or master • Resources or supports the participant intended to access but has not • Collaboration and coordination with collateral(s), including other service providers and the participant's family of choice, when appropriate
d) Identification of any emergent needs or significant life events not otherwise documented in the chart	• Change in living situation or housing • Change in relationship status • Loss of a loved one • Change in employment • Connection to a new faith community • Change in custody status • Contact with the criminal justice system • New medical/health diagnosis or change in health status • Hospitalization or crisis respite stay • Change in behavioral health or medical providers • Change in psychiatric medications (type or dose)
e) Documentation that the summary note was reviewed with the participant	• Participant's signature on the note • A narrative description of their participation in the development and review of the note • A notation that the review was meaningfully attempted but refused/declined
f) A description of next steps, when applicable	• Identification of complex care management needs • Connection to a new resource or support • Identification of any new collateral(s) and obtaining consent to release/receive information • Changes to their group/class schedule and the IRP
g) Dated signature of the staff member completing the monthly summary note	

APPENDIX E: EMPLOYMENT INITIATIVE INFORMATION AND RESOURCES

BILLABLE AND NON-BILLABLE EMPLOYMENT INTERVENTIONS IN PROS

Table 7 is intended to help programs with determining whether a specific employment-related intervention or service may be billable or non-billable.

Table 7 Billable and Non-Billable Employment Interventions in PROS

Type of Service or Intervention	Billable as PROS Service	Non-Billable (Funded by PROS Employment Initiative)
Engagement	CRS – Engagement may be appropriate for engaging with the participant to talk recovery and their goals, including as it relates to employment	Brief engagement interactions with a participant that do not meet the minimum duration or threshold for a billable service or engagement focused primarily on employment generally or job tasks that are unrelated to the participant's interests, abilities, or rehabilitative goals.
Vocational or Career Assessment	CRS – Psychiatric Rehabilitation Assessment may be used to assess the work/ employment domain in the context of the comprehensive assessment	Any vocational or career focused assessment that is not part of the overall mental health assessment
Benefits Counseling	CRS – Benefits and Financial Management may include instruction related to income and benefits, including incentives for returning to work.	Completing benefits paperwork or applications on a participant's behalf, without instruction and support to the participant.
Job Development & Rapid Job Placement	CRS, IR, and Clinical Treatment services that support the participant with managing their mental health challenges and barriers as they work toward achieving their employment goals (e.g., coping skills training, building workplace social skills)	Systematic job development and networking with employers Direct support with helping a participant find and procure a job (e.g., resume writing, completing applications, or scheduling or participating in interviews) Interventions with prospective employers to develop employment opportunities specifically tailored to a participant's abilities.
Follow-along support (job retention support)	ORS and Clinical Treatment services that help the participant manage their mental health challenges and barriers as they work toward sustaining their employment goal CRS, ORS, IR, and Clinical Treatment services that help the participant improve their functioning at work and in the community	Job coaching and other interventions that are targeted to helping the participant succeed in a specific job-related task (i.e., "hard skills") Intervention with a participant's employer to resolve an issue regarding the participant or the workplace

IPS AND ONGOING REHABILITATION AND SUPPORT

IPS and ORS are not synonymous. IPS may be delivered through a number of billable and non-billable services and interventions. When a PROS program implements IPS, they should be using a variety of CRS, IR, and ORS, along with non-billable activities and interventions to support the participant with choosing and getting a job. ORS focuses on helping the participant with keeping, or sustaining, a job and best aligns with the IPS principle of time-unlimited supports, providing individualized follow-along mental health supports after a participant has attained competitive, integrated employment.

IPS AND INTENSIVE REHABILITATION GOAL ACQUISITION

Intensive Rehabilitation – Goal Acquisition (IR-GA) is an excellent tool for implementing Medicaid billable IPS interventions.

Using Goal Acquisition, the Employment Specialist helps the participant to explore the various topics within the context of how mental health challenges have created barriers to employment. The focus is on discovering the participant's unique abilities, talents, skills, and resources, as well as supporting the participant to consider what they believe would be the best possible employment situation.

After the participant identifies a potential job match based on their strengths, talents, and interests, there are additional areas to examine. What steps must the person take to attain employment in this area? What mental health barriers must they overcome to take these steps? What supports will they need to participate in an interview? How will they manage the challenges they experience because of mental health challenges and continue to be successful on the job?

The Employment Specialist can use IR-GA to support the participant in navigating the job application, interviewing, and hiring process. At times during the rapid job search process, the Employment Specialist may need to provide the participant with a level of direct employment support that is not billable under Medicaid (see chart above).

EXAMPLES OF IPS IN MEDICAID BILLABLE PROS SERVICES

Below are some additional examples of how IPS practices are effectively delivered through PROS services. This list is not meant to be all inclusive but rather offers a framework for considering how IPS practices can be smoothly and effectively implemented into PROS service delivery.

- CRS – Individual Recovery Planning: The participant and Employment Specialist work together to identify barriers that are preventing the participant from attaining competitive, integrated employment and the steps that can be taken to overcome these challenges. (IPS Principles: Work Incentives Planning and Zero Exclusion)
- CRS – Psychosocial Rehabilitation:
    - The Employment Specialist employs benefits and financial management skill building to help the participant learn more about and explore how to balance benefits with competitive employment and fiscal self-sufficiency. (IPS Principles: Work Incentives Planning/ Benefits Counseling)
    - Psychosocial rehabilitation services (e.g., basic living skills training, structured skill development and support, and wellness self-management) under the CRS component may be used to support participants with building and developing soft skills related to employment, including but not limited to social skills necessary for workplace interactions, coping skills for anxiety in the workplace, organizational and time management skills, etc. It is important that under the IPS

framework, programs do not operationalize these services as a “prevocational” prerequisite to employment, but rather offer individualized and group-based services to participants while they are actively seeking employment. (IPS Principle: Rapid Job Search)

- IR –Goal Acquisition: The participant and Employment Specialist work intensively to assist the participant to attain their employment goal by overcoming/managing mental health barriers; this service may be provided at any time as part of employment services and may include intensive work on developing and implementing the participant’s Individualized Recovery Plan (IRP). (IPS Principle: Rapid Job Search)
- Ongoing Rehabilitation and Support: The Employment Specialist continues to meet with the participant at least twice per month to address mental health barriers in the workplace. (IPS Principles: Time-unlimited follow-along supports)

CONNECTION TO OUTSIDE EMPLOYMENT RESOURCES

Successfully supporting a participant’s employment goal often means collaboration with other service systems and existing regional infrastructure. Upon request, OMH can provide support and assistance in linking PROS programs to employment resources available through other state agencies, for example the Department of Labor and Adult Career and Continuing Education Services - Vocational Rehabilitation (ACCES-VR). OMH Employment Liaisons are uniquely equipped and available to PROS providers to facilitate these and similar connections, as well as providing technical assistance for effective systems coordination.

Additional Guidance Related to ACCES-VR and Employment Services in PROS:

When available and appropriate, services and support through ACCES-VR may be helpful for PROS participants. However, ACCES-VR services are not essential for a PROS program to successfully deliver IPS services.

Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR) and PROS: Duplicative Services

When a participant chooses to receive services through both ACCES-VR and PROS, it is the responsibility of the PROS program as a Medicaid-billable program to ensure there are no duplicative services.

Both PROS and ACCES-VR offer services that help people attain employment.

The PROS program provides services to overcome mental health barriers that may prevent a person from being successful at employment but does not provide job training or coaching services. PROS participants should have the option to receive training and skill development offered by ACCES-VR for specific jobs. In such cases, it is the responsibility of the PROS provider to ascertain, via the participant’s ACCES-VR’s Individualized Plan for Employment (IPE), the type of services the participant is receiving through ACCES-VR. Once a review of the person’s ACCES-VR plan is completed, the PROS provider may bill for any eligible Medicaid service related to employment rendered by PROS as long as that service does not duplicate any services paid for by ACCES-VR.

Transitioning Participants from ACCES-VR Intensive Services at a Non-PROS Agency to Employment Support Services at a PROS Agency

ORS is one of two approved options to provide extended employment services for adults with serious mental illness who become employed through ACCES-VR intensive services. (Ongoing Integrated Supported Employment, or OISE, is the other approved service to meet this need.)

When an individual receiving ACCES-VR intensive services becomes employed, the ACCES-VR vendor is responsible for connecting that individual to extended supported employment, either through PROS ORS or OISE, if available in their area. When such a referral is made to PROS, it is expected that the program will begin outreaching the individual and their ACCES-VR intensive services vendor to initiate as seamless a transition as possible. The PROS program and ACCES-VR vendor should obtain signed consents at the point of referral to ensure ongoing communication and collaboration throughout and after the transition process. The individual may begin the intake and admission process at PROS as soon as they are ready, but ORS in PROS should not begin until the individual has been stabilized in their position and has been discharged from ACCES-VR.

At the point of job stabilization, the employment services will transition over to PROS and ORS will be used to provide extended employment services.

In many cases when ACCES-VR makes a referral for extended employment services, ORS is the *only* PROS service that individual may be seeking. PROS programs must have policies and procedures to support the referral and admission process for ORS-only referrals, ensuring that such individuals have rapid access to extended employment services with as few barriers as possible.

APPENDIX F: STAFF TRAINING & RESOURCES FOR PROS

STAFF TRAINING & COMPETENCIES GUIDANCE

Program-specific training requirements, recommendations, and resources are outlined in PROS Staff Training & Competencies Guidance, which is an addendum to this Program & Operations Manual. These training requirements are intended to support the delivery of high quality, evidence-based practices within PROS. The guidance includes information and links to a number of OMH-funded training and technical assistance providers.

WEB RESOURCES & ADDITIONAL STATE GUIDANCE

WEB RESOURCES

OMH Websites

OMH Main Page

Guidance: Provides general information or guidance for licensed providers.

PROS Homepage: Hosts PROS-specific information, guidance, newsletters, and forms.

Field Offices: Includes basic contact information for local OMH Field Offices.

Medicaid Reimbursement Rates: Includes approved Medicaid fee-for-service rates for OMH programs.

Behavioral Health Managed Care: Includes information and guidance related to Medicaid Managed Care, including billing and claiming, utilization management, and policy.

Division of Quality Management: Includes information and resources related to licensing/ certification, clinical risk management, and incident reporting.

Mental Health Provider Data Exchange (MHPD): Links to information about MHPD and for logging into the system.

Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES): Includes information, training materials, and login information for the PSYCKES application.

Suicide Prevention: Training, support, and resources related to suicide prevention.

Vital Signs Dashboard: An interactive Tableau dashboard which visualizes the public mental health system's performance in select mental health programs and focuses on disparities in access, quality, and treatment outcomes among Medicaid individuals with mental health needs.

Other NYS Websites

Adult Career & Continuing Education Services – Vocational Rehabilitation (ACCES-VR)

- Find your local District Office

- Help someone Apply for Services
- Get information on local Adult Education Programs and Policy

Department of Health (DOH)

New York Employment Services System (NYESS)

New York State of Health (NYSOH): Official Health Plan Marketplace

- Help someone find an Assistor, Navigator, or Broker to provide assistance with health plan eligibility and enrollment

Office for People with Developmental Disabilities (OPWDD)

- Connect someone with their regional office's Front Door to apply for eligibility

Office of Professions (OP)

Office of Addiction Services and Supports (OASAS)

ADDITIONAL STATE GUIDANCE

PROS Billing and Claiming Manual

New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual

Telehealth Services Guidance for OMH Providers

COVID-19 Infection Control Manual for Public Mental Health System Programs

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