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a division of DBHIDS

CLINICAL PERFORMANCE STANDARDS

Psychiatric Rehabilitation Services (PRS)

Updated July 2026

Community Behavioral Health

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1. PURPOSE

The purpose of the Psychiatric Rehabilitation Services (PRS) Clinical Performance Standards (CPS) is to establish expectations for the delivery of PRS within the CBH network. PRS are guided by **55 Pa. Code § 5230** and are designed to support individuals in developing skills to live, learn, work, and socialize in the community.

The PRS State regulations establish the minimum requirements for obtaining an operating license for PRS and apply to all counties across the Commonwealth of Pennsylvania.

Additionally, the PRS CPS provide a "blueprint" for the delivery of PRS to CBH members and reflect the core values and principles of the City of Philadelphia Department of Behavioral Health and Intellectual Disability Services (DBHIDS) **Practice Guidelines for Resilience and Recovery-Oriented Treatment**. These CPS serve as a tool to promote continuous quality improvement and progression toward best practice performances, increase the consistency of service delivery, and improve outcomes for members.

The objectives for PRS include, but are not limited to:

- Providing assertive outreach and initial engagement to members who are eligible for this service and/or who are referred for this service;
- Assessing, with the member, their needs and preferences in terms of skills and supports they want to develop;
- Educating the member about behavioral health challenges and recovery techniques;
- Collaborating with the member who leads the development of their rehabilitation plans;
- Collaborating with the member in achieving and maintaining rehabilitation goals, as well as how to reconnect with services after discontinuation if needed;
- Collaborating with the member in assessing and utilizing resources in their community (e.g., natural supports, self-help groups, vocational and educational specialists, etc.); and
- Collaborating with the member in developing skills needed to live, work, learn, and socialize in the environments of their choice.

2. ELIGIBILITY

To be eligible to receive PRS, a member must*:

- Be 18 years of age or older (members age 14-17 can be accepted if the program description indicates services for youth); AND
- Have a written recommendation for PRS by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of professional practice, including Physician (MD), Physician Assistant (PA),

Certified Registered Nurse Practitioner (CRNP), Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), and Licensed Marriage and Family Therapist (LMFT); AND

- Have a current behavioral health diagnosis of a serious mental illness, including, but not limited to, schizophrenia, major depressive disorder, schizoaffective disorder, other specified schizophrenia spectrum and other psychotic disorder, bipolar disorder, anxiety disorders, borderline personality disorder, or posttraumatic stress disorder; AND
- Have moderate to severe challenges in functioning in at least one of the following domains as a result of their behavioral health challenge(s): living, learning, working, socializing, or wellness; AND
- Choose to participate in the service voluntarily.

***Exception**: A member who does not meet the diagnostic requirement is eligible for PRS if they have written documentation from an LPHA that includes a diagnosis of a mental, behavioral, or emotional disorder that is listed in the current DSM-5 or ICD-10, which results in a moderate to severe functioning impairment in at least one of the domains.*

3. SCOPE OF SERVICES

3.1. PRS Overview

PRS are governed by **55 Pa. Code § 5230** and further informed by the **PA Office of Mental Health and Substance Abuse Services (OMHSAS)** guidance, including its **frequently asked questions memorandum issued on March 12, 2025**.

PRS are evidence-based, recovery-oriented rehabilitative services that are used to reduce the disabling effects of a mental, behavioral, or emotional disorder and restore a member to live, learn, socialize, and work in their community and to improve their physical and mental health. PRS may decrease the need for or shorten the lengths of stay in inpatient, partial hospitalization, or outpatient treatments.

Services include identifying strategies to minimize the negative effects of a mental, behavioral, and emotional disorder; developing and teaching skills to support functional gains; and assisting the member with living in the community.

PRS is delivered using a rehabilitation process that includes assessing, planning, and intervening phases. Programming and service delivery support members in identifying, achieving, and maintaining valued roles and actively promote engagement in PRS through strategies such as building rapport, tailoring activities to interests, and outreach when participation declines, all within a recovery-oriented environment.

PRS may be provided regardless of involvement in other mental health services (see duplicative services below) and should begin as soon as possible following diagnosis, consistent with the PRS approach identified in the agency's OMHSAS-approved service description. The PRS approach includes evidence-based and best practices utilized in PRS.

When appropriate and with consent, programs are expected to involve natural supports and coordinate with other services to support community participation and continuity of care.

3.2. Core PRS Domains

All PRS services connect to at least one domain and support the acquisition or strengthening of skills and competencies that can be applied in daily life. Domains include:

1. **Living**: Focus on daily activities that support independence and stability
    - Functional skills and competencies include: Managing finances, budgeting, paying bills; planning and preparing meals, and food shopping; scheduling and completing chores; using transportation; using reminders to manage appointments; accessing healthcare and benefits; organizing and maintaining living spaces; problem-solving daily challenges
    - Valued roles include: Tenant, roommate, caregiver, pet owner
2. **Learning**: Focus on educational advancement and habits that support learning and follow-through
    - Functional skills and competencies include: Following multi-step instructions; breaking tasks into steps; time management and planning; using technology for learning; developing study or reading habits; joining community classes; using memory and focus strategies
    - Valued roles include: Student, learner, class participant
3. **Working**: Focus on exploring and preparing for employment or volunteer opportunities
    - Functional skills and competencies include: Identifying vocational strengths and interests; preparing applications and resumes; practicing interviews; learning workplace communication; developing routine and reliability; coping at work; addressing logistical barriers
    - Valued roles include: Volunteer, employee, job seeker
4. **Socializing**: Focus on communication, relationships, and community participation
    - Functional skills and competencies include: Initiating and maintaining conversations; listening skills; boundary-setting and assertiveness; conflict management; reconnecting with family or friends; joining community groups
    - Valued roles include: Friend, neighbor, community group participant
5. **Wellness**: Focus on self-management of physical and mental health
    - Functional skills and competencies include: Identifying triggers and early warning signs; stress management strategies; wellness planning; developing healthy routines; symptom management tools; building resilience, hope, and motivation

- Valued roles include: Self-advocate, person managing their health, wellness group participant

Psychiatric rehabilitation providers will service multiple populations, including, but not limited to:

- Members diagnosed with intellectual disabilities
- Members with co-occurring mental health diagnoses, physical health, and/or substance use diagnoses
- Members with a forensic history
- Older adult populations
- Members with primary language needs other than English

PRS programming is individualized and designed to support the needs of the population served.

3.3. Rehabilitative Interventions

Rehabilitative interventions are active, structured methods that teach, strengthen, and support functional skills and resources aligned with the member's goals. Interventions are tailored to the member's strengths, interests, and preferred roles.

Rehabilitation interventions may include:

- **Skill Development** (teaching new skills or strengthening existing skills)
  - Modeling, coaching, prompting, role playing, task breakdown, and opportunities for practice in real-life settings
  - Supporting members to use skills across home, school, work, and community environments
- **Psychoeducation**
  - Educating members about mental illness, wellness, and living in recovery
  - Increasing awareness of challenges and strategies to manage them
- **Resource Utilization**
  - Helping members identify and use resources and supports needed to pursue goals
  - Supporting access to community, wellness, and natural supports

- **Structured Skill Programs and Approaches**
  - Evidence-based or best practice PRS approaches, such as Illness Management and Recovery (IMR), Social Skills Training (SST), Recovery-Oriented Cognitive Therapy (CT-R), and the **Boston University Model of Psychiatric Rehabilitation**
  - Peer support approaches that emphasize shared lived experience, peer mentoring, and the development of a **Wellness Recovery Action Plan (WRAP)**

The examples provided are not exhaustive. PRS agencies may use additional interventions consistent with the PRS approach identified in the OMHSAS-approved service description.

Documentation of rehabilitative interventions notes the skill/domain/competency addressed, the method used, and the member's response to the service.

3.4. PRS Modalities and Service Standards

CBH authorizes PRS, which includes community- and site-based services. The goal of all PRS services, regardless of setting, is to minimize the negative effects of a mental, behavioral, and emotional disorder, teach skills to support functional gains across PRS domains, and assist the member with living in the community.

All PRS modalities are delivered using the PRS process (assessing readiness and needs, planning for skills and supports, and intervening through the development of skills and resources), actively engage the member, and support their rehabilitative progress and meaningful participation in the community.

PRS agencies that wish to provide services to members 14 years of age or older but under 18 years of age will need to update their service descriptions to include information about the services they will provide and the staff who will provide PRS to this new population.

3.4.1. Key Regulatory Requirements for PRS Locations

PRS can be site-based (facility-based) or community-based (mobile), or both. The regulations further solidify that services can be rendered in a PRS facility, in the community, or in the member's home, based on the approved service description.

3.4.1.1. Community-Based PRS

Community-based PRS are delivered in natural environments to support skills generalization and community integration. Activities are linked to Individual Rehabilitation Plan (IRP) goals and may include identifying and using community resources, developing natural supports, and supporting housing stability (e.g., connecting to housing resources, assistance obtaining/maintaining housing, coordination with housing providers). Services incorporate opportunities for active practice of rehabilitative skills in real-world settings.

Community-based PRS are delivered individually (1:1) and in group settings, and services for members under 18 and over 18 must occur separately. Groups are voluntary, limited to no more than five members, and facilitated by psychiatric rehabilitation program staff. **55 Pa. Code § 5230.54. Group services** outlines that only PRS program participants, staff, and interns may be included in community groups.

Each group includes preparation and debriefing to reflect on the skills practice. Staff must ensure confidentiality, safety, and professional boundaries in community settings.

3.4.1.2. Facility-Based PRS

All PRS, including PRS delivered in facility settings, are recommended to be complemented with community-based PRS, as one of the overall goals of PRS is to assist members with community integration and living in the community. Facility-based PRS supports structured learning and skill rehearsal before applying them in community settings. Facility-based services are delivered individually (1:1) and in group settings, and services for members under 18 and over 18 must occur separately.

PRS programs must align with PRS regulations, bulletins, and policy clarifications regarding maximum group size and staff-to-member ratios. Per **OMHSAS Bulletin 26-01**, the maximum group size for facility-based PRS must be documented in the provider's State-approved service description.

During documentation review, CBH may request the provider's PRS service description to verify compliance with the approved maximum group size. Providers must ensure effective group services and consider the appropriate group size when delivering them.

Individual and group services are linked to IRP goals and delivered through guided, interactive activities focused on skills and competencies. Group services reflect common IRP-aligned rehabilitative goals of the members attending the group. Groups have a defined topic or skill focus, promote participation and positive peer interaction, and focus on psychiatric rehabilitation rather than clinical processing.

Sessions are facilitated by PRS staff. Members may lead or co-facilitate group activities under direct staff supervision when the purpose is to develop peer leadership or communication skills. When this is the case, staff will provide preparation, observation, and debriefing to ensure the session maintains rehabilitative focus.

3.4.1.3. Telehealth PRS

Telehealth PRS involve active rehabilitative interactions and follow **OMHSAS Bulletin 21-09** and **CBH Telehealth Best Practice Guidelines** (under the "Additional Documents" tab). Services must be billed using the correct place of service (POS) codes and required informational modifiers.

Telehealth PRS can be billed if that same service is covered as it would be delivered in person. Telehealth may be used for communication and coordination, but it is not billable as PRS. Documentation must clearly show the rehabilitative purpose and service provided. Telehealth check-ins, administrative contacts, or other non-rehabilitative interactions are not billable as PRS.

3.4.1.4. Duplicative Services

PRS must be distinct from other services and may not duplicate interventions being provided by another program or provider. PRS agencies are expected to collaborate and coordinate with other service agencies, with the member's consent, to avoid duplication.

Members receiving Assertive Community Treatment (ACT) are not eligible for PRS.

3.4.1.5. Billable and Non-Billable Activities and Events

PRS billing is strictly limited to activities and interventions that directly support a member's goal-linked rehabilitative needs. PRS are not able to bill non-member-facing activities, such as travel without the member. Generally, non-rehabilitative interactions, such as meals, breaks, passive social activities (e.g., hanging out, watching movies), drop-in attendance, check-ins, and administrative contacts, are not billable as PRS.

A "gray area" exists when events and activities that may be beneficial for mental health recovery—fostering a sense of community, reducing isolation, building social connections—do not meet the criteria for a billable service under Medicaid. For an activity to qualify, it must be medically necessary, goal-oriented, and structured as a therapeutic intervention under the oversight of qualified professionals.

PRS do not cover activities that are purely recreational, passive, social, or entertainment. Events such as parties or celebrations are non-billable if they are unstructured social gatherings that lack a documented rehabilitative purpose tied to a member's IRP.

Examples of non-billable activities include:

- A general "holiday party" focused primarily on socializing, eating, or watching a movie without a structured therapeutic goal.
- Unstructured "drop-in" time, socializing with peers.
- A sporting event attended for leisure and entertainment.

Events and activities, such as holidays, parties, or socialization, can only be billed as PRS if they are intentionally structured, actively facilitated, and documented specifically to teach or strengthen skills and competencies related to a member's rehabilitation goals.

Examples of billable activities include:

- A structured "Social Skills Building" group where participants plan a party menu and practice specific communication and conflict resolution skills during the process
- Facilitated and documented peer interaction focused on initiating conversation, problem-solving, and using coping strategies
- A community event where a staff member works one-to-one with a member to manage stress triggers and practice community integration skills
- A community-based group (e.g., park, library, or free community event) with active staff coaching to support real-time practice of social interaction and community navigation skills

4. CLINICAL MANAGEMENT

4.1. Referrals

PRS referrals must be submitted by way of the **CBH PRS Referral Form** to CBH via ***CBH Box*** by PRS providers or bed-/community-based referral sources. The referral form must be completed and signed legibly.

Once CBH receives a PRS referral, CBH has 48 hours (two business days) to respond to the referral source, indicating approval or need for additional information. If the referral has insufficient information, the provider will have 14 days to submit the required information before the referral is completely denied for insufficient information.

If the referral is determined sufficient (i.e., completed referral with requirements documents), CBH will notify the PRS referral source of approval, generate the authorization, and provide InfoShare. If the referral was received from a community- or bed-based referral source, CBH will identify a PRS provider based on availability and access, notify the referral source via outcome notification, generate an initial PRS authorization for 60 days of treatment, and provide the PRS provider with InfoShare. It is expected that all PRS providers complete a monthly capacity and availability report to support new referrals from community- or bed-based referral sources.

A PRS provider will initiate contact with a new member within three days of authorization and conduct an in-person meeting within five business days of authorization.

4.2. Initial and Concurrent Review Process

Initial review will occur on the last covered day of the initial authorization. The PRS provider will submit the IRP and the assessment electronically via *CBH Box* before the last covered day. CBH will review for a 90-day extension and conduct a telephonic review at the end of the following authorization process to determine continued services. If the member continues to meet **medical necessity criteria (MNC)**, services will be authorized up to 90 days. If the member does not continue to meet MNC, a consult will be completed with a CBH physician.

Members must be assessed for continued stay in PRS on an ongoing basis. Though IRPs are to be reviewed and updated with the member every 90 days, concurrent reviews can occur at any time within 90 days, as needed to follow up on progress or the quality of support for the member. The current IRP should be available for review at any given time. Concurrent reviews will be facilitated telephonically. During the concurrent review process, CBH may request follow-up and clarification of services during the extension time, to be provided at the next review. To meet the requirements for continued stay, a member must agree to continued participation, and there must be a continued need for services based on at least one of the following:

- As a result of a mental illness, there is a functional impairment or skill deficit that is addressed in an individual service plan (ISP)
- The withdrawal of service could result in the loss of rehabilitation gains or the goal attained

The most up-to-date review templates will be available in the **CBH Provider Manual**.

4.3. Discharge Planning Process

A member may choose to transition from PRS when they have determined that they:

- Have achieved their goals, OR
- Are ready to transition to the community, OR
- no longer want to participate in PRS.

The member shall lead discharge planning in collaboration with staff if the member refuses engagement for 30 days, consistent with **55 Pa. Code §§ 5230.71** and **5230.72**.

Documentation of discharge planning shall include, but is not limited to, the following:

- Rationale for transitioning the member from the service, including assertive attempts to engage or re-engage the member if the member is being discharged due to disengagement in services
- Service(s) provided
- Outcomes and progress of PRS goals
- A crisis management plan, initiated at the start of services
- Referral or recommendations for future services
- Coordination of care among all current and needed services and natural supports
- Sharing information about options for returning to PRS and/or to other available resources and supports
- Signature of the member and an opportunity to provide feedback
- A discharge/disengagement summary, signed by the PRS director, completed no more than 30 days after disengagement

If there is a failure to connect with a member for 30 days after the last contact, it is the responsibility of the agency to implement standardized procedures within its agency and to follow up with CBH staff to support next steps in transitioning the member.

After 60 days without contact, if the PRS team is still unable to locate the member, a discharge can be submitted. Supportive documentation describing ongoing attempts to locate the member should be included in the member's record/discharge summary.

If the PRS team is unable to locate a newly authorized member within 30 days of the authorization date, a discharge can be submitted.

If a former PRS member requests to be readmitted to the PRS provider within 60 days of being closed, the member can be readmitted to PRS by submitting an updated summary indicating the member's needs with an initial authorization request.

5. PRS PLANNING AND DELIVERY

PRS must be planned, delivered, and documented in a manner consistent with psychiatric rehabilitation principles and compliant with 55 Pa. Code § 5230, CBH requirements, and Medicaid billing standards. This section defines the process that translates assessment findings into individualized goals, guides service delivery, and documents progress.

5.1. Assessment

The assessment is completed collaboratively with the member, reflects the member's strengths, needs, interests, and preferences, and identifies the skills and resources needed to pursue rehabilitation goals. It serves as the basis for IRP development and determination of service intensity. Initial assessment is completed at admission and before the development of the initial IRP.

5.1.1. Required Assessment Elements

Each assessment addresses:

- **Functioning** across the five PRS domains includes: living, learning, working, socializing, and wellness. Examples appear in Section 3.2.
- **Strengths and Needs** are functional skills, coping strategies, personal qualities, supportive relationships, and current barriers relevant to rehabilitation, including functional limitations, areas requiring support, and environmental challenges. Strengths and needs reflect the member's current functioning and directly inform the skills, supports, and resources addressed in IRP. Learning preferences should also be noted.
- **Skills, Supports, and Resources** include specific skills the member wants or needs to learn to achieve goals; natural supports (family, peers, community); formal supports (behavioral health, healthcare, human services); and resources (vocational, educational) needed for rehabilitation. Learning preferences should also be noted.
- **Cultural, Preference, and Participation Factors** include cultural values, language, communication style, spiritual or personal factors that may influence motivation, participation, and learning.
- **Collaboration and Consent** refer to the participation of natural supports that require the member's consent. Staff will review findings with the member and confirm their agreement before finalizing their documentation.

5.1.2. Review and Update

Assessments are updated at least annually, or sooner if requested by the member, if goals change, or if progress indicates new barriers or priorities. Updates summarize progress, regression, changes in supports or environment, new needs, goals, or barriers, and IRP changes needed.

5.1.3. Signatures

Assessments are signed and dated by the member and PRS staff completing the assessment.

5.2. Individual Rehabilitation Plan (IRP)

The IRP translates assessment findings into individualized rehabilitation goals and active methods to build and support the skills, competencies, and resources needed for valued roles and community participation. Plans are developed with the member's participation and reflect their preferences and priorities.

Per **55 Pa. Code § 5230.62. Individual rehabilitation plan**, initial IRP is completed by day 20 of attendance, and no later than 60 calendar days after the first contact. In alignment with **§ 5230.3**, a goal is the purpose of rehabilitation service as identified by the member, and an outcome refers to an observable and measurable result of PRS.

5.2.1. Required Plan Elements

- **Goals** are based on assessment findings and directly tied to functional skills, supports, and resources needed to further the member's rehabilitation. Goals must be clear, measurable, and allow staff to document progress toward the outcome. *SMART goals* are a structured framework for making goals more Specific, Measurable, Achievable, Relevant, and Time-bound, and can be used to create goals.

  Providers may choose to include objectives as a best-practice tool to break goals into smaller learning steps. Objectives specify the skills or behaviors that will be learned to strengthen the goal; they also support clearer documentation and progress tracking.

- **Skills, Supports, and Resources** correspond to those identified in the assessment. With consent, natural supports or formal service providers may participate in IRP planning or implementation. The plan reflects the member's preference regarding involvement of others and ensures coordination when it supports goal achievement. Supports may supplement but do not replace PRS staff responsibilities.

- **Method of Service Provision** describes how PRS will assist the member (e.g., modeling, coaching, role-playing, skill practice, psychoeducation, resource navigation) based on the member's identified needs and learning preferences.

- **Responsibilities of Members and Staff** include concrete, achievable action steps that are defined, achievable within 90 days, and reflect active participation. They are stated in clear, behavioral terms—what the member will do to work on their goal, and what the staff will do to teach, guide, or support it.

- **Frequency and Duration of Services** are specified in the member's IRP. This includes how often PRS will occur and the typical session duration. Any changes must be documented and reviewed with CBH Clinical Management during concurrent review.

- **Cultural, Communication, and Participation Considerations** reflect relevant cultural or communication needs, preferences, and motivational factors identified in the assessment.

5.2.2. Review and Update

Each IRP specifies start and review dates. Per regulation, it is reviewed and updated at least every 90 calendar days, or sooner if a goal is completed, no significant progress has been made, or the member requests an update.

Reviews include a comprehensive summary of:

- Services provided by PRS staff for each goal
- Member participation and response to services
- Progress or lack of progress toward the goal
- Summary of changes made to the updated plan

5.2.3. Signatures and Documentation Standards

IRPs are signed and dated by the member, the PRS staff working with them, and the PRS program director. If the member does not sign, the reason for the missing signature is documented; subsequent attempts to obtain the signature are made and documented.

Plans lacking required signatures are not valid, and services provided during periods without a valid plan may be subject to overpayment recovery.

5.3. Service Delivery and Documentation

PRS service delivery translates the IRP into active rehabilitation encounters designed to help the members learn, strengthen, or apply functional skills and/or identify and use resources needed for recovery. Services are delivered in a goal-directed manner and documented.

5.3.1. Service Definition

Billable PRS:

- Are structured and documented
- Are delivered individually or in groups
- Have defined start and end times
- Reflect a rehabilitative purpose
- Relate directly to IRP goals
- Support active participation and opportunity for learning or practice
- Are facilitated by qualified staff

5.3.2. Settings and Modalities

Services may occur:

- In a PRS facility (structured learning, peer engagement)
- In the community (real-world practice and resource access)
- In a member's home, as applicable

5.3.3. Documentation Requirements

Providers may document PRS using a weekly, daily, or per-service format; however, all of the following required documentation elements must be included, regardless of the format:

- **Identification of the member** on every page or system entry
- **Service date with start and end clock times**
- **Delivery setting** (i.e., group vs. individual) and **service location** are required to meet State staff-to-individual ratio requirements. Facility-based PRS groups must comply with the maximum group size limit established in the provider's **S**tate-approved service description, and group notes must provide sufficient detail to allow verification of compliance with established group size limits. Community-based PRS groups are limited to five participants, and documentation reflects preparation prior to the group session and debriefing following it.
- **Rehabilitative purpose and intervention** showing a connection between the service, IRP goal, and structured intervention or activity
- **Member participation and response** documented by staff, including observed behaviors or use of skills, intervention effectiveness, progress, and identified barriers, demonstrating the service outcome
- **Member level of engagement (attendance and participation)** documented for the applicable service period (e.g., weekly, daily, per service)
- **Dated signatures** by each staff member providing services during the documented period
    - » See Question #8 in the OMHSAS-issued memorandum, **"Psychiatric Rehabilitation Services – Chapter 5230: Frequently Asked Questions"** (March 12, 2025).
- Member record updates show **progress over time**, which means documenting improvements in goals and service focus. If progress stalls, the record reflects **adjustments** made to goals, service focus, or approach.
- **Daily attendance records**, including daily start/end times and session/activity, are maintained and available upon request.
- **Encounter form** for recipient verification of service (see **MA Bulletins 99-89-05** and **99-03-21**)

- Documentation is expected to be **legible, accurate, timely, and consistent** across the IRP, service documentation, attendance records, encounter forms, and claims.

Members are encouraged to share their perspectives on the services they receive, but their input in service documentation is voluntary. Staff who provide the service remain responsible for maintaining accurate and complete service documentation. Supervisors are responsible for regularly reviewing documentation to ensure services are rehabilitative, consistent with IRP, and authorized.

5.3.4. Additional Requirements

The documentation requirements listed here are not exhaustive. Providers are also required to comply with all applicable PA laws and Medicaid requirements, including **55 Pa. Code §§ 1101** and **5230**, guidance provided via **MA Bulletins and OMHSAS communications**, and requirements outlined in the **CBH Provider Manual**, **CBH Provider Bulletins**, and other issued CBH guidance (e.g., **CBH Provider News Blast** updates). Providers are responsible for monitoring and implementing the updates.

6. STAFFING REQUIREMENTS

This section summarizes key staffing expectations and is not exhaustive. Providers remain responsible for compliance with all applicable staffing requirements in **55 Pa. Code § 5230**. In addition, PRS providers are expected to comply with CBH personnel requirements, as outlined in the **CBH Manual for Review of Provider Personnel File (MRPPF)** (located under the "Credentialing" tab), including requirements for staff credentials, clearances, training records, and waivers.

Staffing in PRS ensures that services are delivered safely, effectively, and in accordance with regulatory requirements. This section outlines staffing structure, qualifications, supervision, and training requirements necessary to support high-quality psychiatric rehabilitation service delivery.

Per **55 Pa. Code § 5230.15**, the PRS agency service description includes, among other required elements, key staffing information, including staffing patterns, staff-to-member ratios, staff qualifications, supervision plans, and training protocols. Providers are expected to review and update their service descriptions when changes occur to reflect current practices and to submit them to OMHSAS for approval.

6.1. General Staffing Requirements

PRS programs are required to maintain a staffing structure and qualifications consistent with **55 Pa. Code § 5230.51**. At a minimum, agencies will employ a PRS Director and a Psychiatric Rehabilitation Specialist. Additional roles, including Psychiatric Rehabilitation Workers and Psychiatric Rehabilitation Assistants, may be utilized based on the program's service model. When services are delivered, a Psychiatric Rehabilitation Specialist or Psychiatric Rehabilitation Worker must be present.

PRS programs are also expected to comply with the general staffing requirements under **55 Pa. Code § 5230.52**, including:

- Having sufficient staff to provide individual and group PRS

- Ensuring staff are scheduled and present to deliver planned services
- Designating a qualified staff person responsible for supervision

6.2. Staff-to-Member Ratios

PRS programs must maintain staffing levels to ensure the safe and effective delivery of services. Staffing ratios are met using qualified program staff directly involved in service delivery. PRS programs must align with PRS regulations, bulletins, and policy clarifications related to staff-to-member expectations.

6.2.1. Individual PRS

Individual services are provided 1:1—one staff to one member—and may be delivered in the facility or community-based settings.

6.2.2. Group PRS

PRS staff members provide facility-based group services and accompany the group if it is facilitated in the community. Facility-based maximum group size must be documented in the provider's State-approved service description and is subject to verification during CBH reviews. Community-based groups may include no more than five members. Only PRS staff, members receiving PRS, and PRS interns may participate.

6.3. Staff Qualifications

Staff must meet one of the qualification pathways outlined in **55 Pa. Code § 5230.51**. These pathways vary by staff role (director, specialist, worker, assistant) and by whether the agency serves adults 18+ or youth ages 14-18. Different pathways include combinations of:

- Psychiatric rehabilitation credentials (e.g., CPRP, CFRP)
- Bachelor's or associate degrees with or without experience, depending on the pathway
- High school diploma/GED combined with relevant experience.

6.4. Supervision Requirements

Supervision must comply with **55 Pa. Code § 5230.55** and be documented.

Required components include:

- **Staff member** supervision at least twice per calendar month for at least 30 minutes each
- **Audio-only** supervision is not permitted.
- **Group** supervision may include observing service delivery, attending staff meetings, and discussing approaches used to assist members in attaining their rehabilitation goals.
- Supervisors conduct **documentation reviews** to ensure:

- PRS rehabilitative methods are being used
- Services are aligned with IRP goals
- Documentation is timely and complete

6.5. Training Requirements

PRS programs ensure all staff receive initial and ongoing training required for safe and competent rehabilitation service delivery. This section summarizes the major training themes; providers are expected to consult **55 Pa. Code § 5230** and the MRPPF for the full list of required topics and specifications, maintain documentation of all completed trainings, and make it available upon request.

6.5.1. Regulatory Training Requirements

Staff receive initial and ongoing training focused on:

- Psychiatric rehabilitation, recovery practices, resiliency, or a combination of the three
- The specific PRS model/approach described in the agency's approved service description
- Additional youth-specific training when working with members 14-18, including mandated reporter requirements.

6.5.2. CBH Training Requirements

CBH requires additional training for PRS staff beyond state regulation. The PRS CPS do not enumerate specific CBH training topics; instead, providers are expected to refer to the current MRPPF for CBH-mandated training topics, frequency, role-specific requirements, documentation, and policy expectations.

6.6. Staffing and Program Culture

CBH expects staffing patterns to support a program environment that is:

- Rehabilitative, not custodial
- Recovery-oriented, person-centered, and strength-based
- Trauma-informed
- Focused on the development, enhancement, and retention of skills and competencies across the five PRS domains, so members can live in the environment of choice and participate in the community

7. REFERENCES

- **CBH Provider Manual**
- **CBH Manual for Review of Provider Personnel File (MRPPF)**
  located under the "Credentialing" tab
- **CBH Clinical Documentation Requirements: Specific Levels of Care, Section 2. Group Services**
  located under the "Program Integrity" tab
- **CBH Telehealth Best Practice Guidelines**
  located under the "Additional Documents" tab
- **55 Pa. Code § 5230: Psychiatric Rehabilitation Services**
- **OMHSAS Bulletin 21-09: Guidelines for the Delivery of Behavioral Health Services Through Telehealth**
- **Medical Assistance Bulletin 99-03-21**
- **Medical Assistance Bulletin 99-89-05**
- **OMHSAS Memorandum: Psychiatric Rehabilitation Services – Chapter 5230: Frequently Asked Questions**
- **Boston University Model of Psychiatric Rehabilitation**
  a person-centered, educational approach that helps individuals with severe mental health conditions live, learn, work, and socialize in their chosen environments
- **Wellness Recovery Action Plan (WRAP)**
  a simple and powerful process for creating the life and wellness you want, the WRAP process supports you to identify the tools that keep you well and create action plans to put them into practice in your everyday life