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Pursuant to State Government Article, §7-206, Annotated Code of Maryland, this issue contains all previously unpublished documents required to be published, and filed on or before December 17, 2007, 10:30 a.m.

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, I hereby certify that this issue contains all documents required to be codified as of December 17, 2007.

Dennis C. Schnepfe
Administrator, Division of State Documents
Office of the Secretary of State

Final Action On Regulations

Symbol Key

- Roman type indicates text already existing at the time of the proposed action.
- *Italic type* indicates new text added at the time of proposed action.
- Single underline, italic indicates new text added at the time of final action.
- Single underline, roman indicates existing text added at the time of final action.
- ~~[[Double brackets]]~~ indicate text deleted at the time of final action.

**Title 10
DEPARTMENT OF
HEALTH AND MENTAL HYGIENE**

Subtitle 21 MENTAL HYGIENE REGULATIONS

Notice of Final Action

[07-160-F]

On December 18, 2007, the Secretary of Health Mental Hygiene:

(1) Adopted the repeal in their entirety of Regulations **.01—.12** and new Regulations **.01—.16** under **COMAR 10.21.16 Community Mental Health Programs—Application and Approval Processes**;

(2) Adopted the repeal in their entirety of Regulations **.01—.14** and new Regulations **.01—.17** under **COMAR 10.21.17 Community Mental Health Programs—Definitions and Administrative Requirements**; and

(3) Adopted the repeal in their entirety of Regulations **.01—.08** and new Regulations **.01—.11** under **COMAR 10.21.20 Community Mental Health Programs—Outpatient Mental Health Centers**.

This action, which was proposed for adoption in 34:15 Md. R. 1363—1381 (July 20, 2007), has been adopted with the nonsubstantive changes shown below.

Effective Date: January 14, 2008.

Attorney General's Certification

In accordance with State Government Article, §10-113, Annotated Code of Maryland, the Attorney General certifies that the following changes do not differ substantively from the proposed text. The nature of the changes and the basis for this conclusion are as follows:

COMAR 10.21.16.01B: Added to clarify what is know that these regulations do not apply to Therapeutic Group Homes or Federally Qualified Health Centers which are regulated under other chapters. It is not substantive revision.

COMAR 10.21.16.04C(3)(f): This information is needed in order to review the application to determine if the applicant meets the requirements under COMAR 10.21.16.07C(2): The need for this information would be implied from those requirements. It is not a substantive revision.

COMAR 10.21.16.04E: This is a clarifying section. When an applicant submits an application it must list the sites where it will provide services. When DHMH approves the application it is

approved based on those sites. An applicant cannot operate past the approval on the original license. This section gives a benefit to the provider who wishes to open additional sites. Rather than submit a new application the provider can ask for a modification of the original application. It is not substantive revision.

COMAR 10.21.16.10C(1): By regulation and law the Department's designated approval unit would have the right to consult. Adding the unit to this regulation clarifies existing authority and is not substantive revision.

COMAR 10.21.17.02B(60): DHMH has promulgated different chapters to regulate providers of psychiatric rehabilitation programs for adults and children. Adding “for adults, and COMAR 10.21.29 for minors, or both” to this definition reflects the state of the current law. It is not substantive revision.

COMAR 10.21.17.04C: Adding that advanced directives requested are for mental health services and not a general advanced directive reflects what was intended and what is current practice. It is not substantive revision.

COMAR 10.21.17.05B(2): The requirements to take members which reflect the date of the meeting, the members present and the topics discussed is a reflection of current good practices for any committee and certainly one that reviews health care decisions. These requirements could be inferred and are just spelled out. These additional regulatory requirements are not substantive revision.

COMAR 10.21.17.05B(5): By adding the word “if applicable” indicates that for profits providers do not have a charitable purpose to satisfy and that this applies only to nonprofit corporations. Adding the word “annually” clarifies when the review is to occur. This reflects the current good business practices for nonprofit boards. It is not a substantive revision.

COMAR 10.21.17.08B(7): This change combines §B(7) and §B(8). Adding the words “necessary to implement the Department's requirements on the setting of charges and collection of fees” indicates the purpose of this regulation and implements the requirements of other laws. It is not substantive revision.

COMAR 10.21.17.09A(4)(k) and (l): Providers are required to report incidents and have a crisis response plan currently. This regulation clarifies that in order to issue such reports and have such plans, the provider must have written policies to implement this requirement. This could be inferred. These changes clarify the inference. It is not a substantive revision.

COMAR 10.21.17.09A(4)(m): As to additions regarding policies about false claims, please note the explanation below regarding the deletion of Regulation .10. This addition reflects current legal requirements, and could have been anticipated since it was covered in the proposed regulations. It is not a substantive revision.

COMAR 10.21.17.10: This regulation has been deleted in its entirety and added under Regulation .09A(4)(m). This is correct since it is a requirement about having a policy informing

employees of the laws and regulations regarding fraud and abuse. Redundant language has been deleted regarding inclusion in the employee handbook. All employees must be informed of all policies. Thus, having a requirement to put this information in an employee handbook was duplicative. This is not a substantive revision.

COMAR 10.21.17.12C: The addition of the words “which may be a component of the QM” reduces the redundancy of having the provider produce two different documents where one can serve the same purpose. This is not a substantive revision.

COMAR 10.21.17.12C(2)(b): Referencing an existing requirement contained in Regulation .14 helps the provider by not having to consult two legal sources. It reduces the burden on the provider without changing the intent of the regulation. This is not a substantive revision.

COMAR 10.21.17.12C(3): Adding the word “evaluates” spells out what is inferred by the intent of this regulation. There is no purpose in collecting information, i.e. tracking, if the information is not evaluated. This is not a substantive revision.

COMAR 10.21.17.13: This completely new regulation gives the provider more information and notice regarding the statutory reporting requirements. It assists the provider by providing by providing forms which will make the report uniform and inform them of what is needed. This is not a substantive revision.

COMAR 10.21.17.16D(1): The language is clarifying that this is a requirement and that the CSA where applicable must be notified. Collaborating with the CSA is a current requirement. This language specifies that the provider must consider involving the CSA when there are complaints. This is not burdensome to the provider. This is not a substantive revision.

COMAR 10.21.17.16F: The words “presents a serious risk” interpret what was meant by “poses a danger”. It was intended that the provider take action only when there is a serious risk, which means a danger. Changing the word “final decision” to “recommendations of the CSA etc.” also clarifies what was intended and was currently occurs. The provider must make the final decision. This is not a substantive revision.

COMAR 10.21.20.06B: The addition of the word “Screening” clarifies what was intended and what is the current practice. This is not a substantive revision. Also, adding the words, “if available” reflects the reality that there are not tools for every age. This is not a substantive revision.

COMAR 10.21.20.07A(1): The addition and deletion of the words in this regulation are related to assuring that this Medicaid services is interpreted as intended, i.e. to meet medical needs and is not a service that is not directed at the mental illness with which the individual presents. This is not a substantive revision.

COMAR 10.21.20.07A(3)(f): The addition of the Certified Registered Nurse Practitioner (CRNP) corrects an unintended omission. Since CRNPs can fulfill this function failure to list them would have been to limit their practice. This was not intended. Having more practitioners

who can deliver these services benefits the providers and consumers. This is not a substantive revision.

COMAR 10.21.20.07B(2): Any proper documentation by a provider would include significant changes or events, including hospitalization, that affect the individual's treatment. Making clear that this is part of professional and required record keeping places the provider on notice of only what the provider should know. This is not a substantive revision.

COMAR 10.21.20.11A: The addition of the words “application modification as outlined in COMAR 10.21.16.04E” clarifies what was meant by the words “requirements of this chapter” which are being deleted. This is not a substantive revision.

10.21.16 Community Mental Health Programs—Application, Approval, and Disciplinary Processes

**Authority: Health-General Article, §§10-901 and 10-902,
Annotated Code of Maryland**

.01 Scope.

A. This chapter outlines the process for application for, denial of, and disciplinary action on, the approval for a program to be eligible to receive State or federal funds for providing community mental health services.

B. This chapter does not apply to programs approved under COMAR 10.21.07 Therapeutic Group Homes or Federally Qualified Health Centers.

.04 Application Process.

A.—B. (proposed text unchanged)

C. *Application. An applicant for approval of a program shall:*

(1)—(2) (proposed text unchanged)

(3) *Include in the application, at a minimum, the following information:*

(a)—(e) (proposed text unchanged)

(f) Disclosure of:

(i) Any license or approval revocation within the previous 10 years by the Department or other licensing agency;

(ii) Whether the program, or corporation or entity associated with the program, has surrendered or defaulted on its license or approval for reasons related to disciplinary action, within the previous 10 years; and

(iii) Any corporate officer who has served as a corporate officer for a corporation or entity that has had a license revoked, or has surrendered or defaulted on its license or approval for reasons related to disciplinary action within the previous 10 years;

[[~~(f)~~]] (g)—[[~~(g)~~]] (h) (proposed text unchanged)

(4) (proposed text unchanged)

D. (proposed text unchanged)

E. Application Modification.

(1) A program that proposes to change its program sites by adding, closing, or moving locations shall submit an application modification, on the form required by the Department, to the Department's designated approval unit.

(2) If the Department's designated approval unit approves the application modification, the existing program approval shall extend to the additional site, as applicable.

.10 Deemed Status.

A.—B. (proposed text unchanged)

C. Evaluation of Request for Initial Deemed Status or Renewal of Deemed Status. Within 60 calendar days of receipt of the request under §A or B of this regulation:

(1) The Administration, in consultation with the CSA or lead CSA, and the Department's designated approval unit:

(a)—(c) (proposed text unchanged)

(2) (proposed text unchanged)

D.—E. (text unchanged)

10.21.17 Community Mental Health Programs—Definitions and Administrative Requirements

Authority: Health-General Article, §§10-901 and 10-902,
Annotated Code of Maryland

.02 Definitions.

A. (proposed text unchanged)

B. Terms Defined.

(1)—(59) (proposed text unchanged)

(60) *“Psychiatric rehabilitation program (PRP)” means a program approved under COMAR 10.21.21 for adults, and COMAR 10.21.29 for minors, or both.*

(61)—(84) (proposed text unchanged)

.04 Consent for Services, Orientation, and Advance Directive for Mental Health Services.

A.—B. (proposed text unchanged)

C. Advance Directive for Mental Health Services. For individuals who are 16 years old or older, the program director shall:

(1)—(4) (proposed text unchanged)

.05 Advisory Committee.

A. (proposed text unchanged)

B. Responsibilities of the Advisory Committee. The advisory committee shall:

(1) (proposed text unchanged)

(2) Maintain documentation of the meetings, including:

(a) Date;

(b) Members present; and

(c) Summary of the topics discussed;

[[(2)] (3)]—[[(3)] (4)] (proposed text unchanged)

[[(4)] (5)] [[Annually]] *If applicable, annually review whether the program is satisfying its charitable mission.*

C.—D. (proposed text unchanged)

.08 Records.

A. (proposed text unchanged)

B. Contents of Record. When an individual is enrolled in a program, the program shall maintain a record of, at a minimum:

(1)—(6) (proposed text unchanged)

[[(7) When required, financial information necessary to implement the Department's requirements on the setting of charges and collection of fees;]]

[[(8)]] (7) Documentation of [[the]] verification of the individual's financial information, or, if the individual is a minor, the minor's parent's financial information necessary to implement the Department's requirements on the setting of charges and collection of fees;

[[(9)]] (8)—[[(16)]] (15) (proposed text unchanged)

.09 Policies and Procedures.

A. The program shall have and maintain written policies that, at a minimum include:

(1)—(3) (proposed text unchanged)

(4) The policies and procedures for:

(a)—(h) (proposed text unchanged)

(i) If the program provides services in a facility, a disaster and emergency evacuation plan; [[and]]

(j) According to federal and State requirements, safety precautions, infection control, and communicable disease control[[.]] ;

(k) Incident reporting;

(l) Crisis response plan; and

(m) Information about any State and federal laws pertaining to civil or criminal penalties for false claims and statements and whistle blower protections, including the necessity for preventing and detecting fraud, waste, and abuse.

B.—C. (proposed text unchanged)

[[.10 Employee Education About False Claims Recovery.

A. All programs approved to receive funds under any Mental Hygiene Administration regulations shall establish written policies for all employees of the program, including managerial employees, and of any contractor or agent of the program that provide direct care or billing services, that provide detailed information about the:

(1) *False Claims Act established under 31 U.S.C. §§3729—3733;*

(2) *Administrative remedies for false claims and statements established under 31 U.S.C. Chapter 38; and*

(3) *Any State laws pertaining to civil or criminal penalties for false claims and statements, and whistle-blower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.*

B. A program shall include:

(1) *As part of its written policies regarding the False Claims Act, detailed provisions regarding the program's policies and procedures for detecting and preventing fraud, waste, and abuse; and*

(2) *In any employee handbook for the program, a specific discussion of the rights of employees to be protected as whistle-blowers.]]*

~~[[.11]]~~ ~~.10~~—~~[[.12]]~~ ~~.11~~ (proposed text unchanged)

~~[[.13]]~~ ~~.12~~ *Quality Management (QM).*

A.—B. (proposed text unchanged)

C. Risk Management (RM). *The program director shall develop and, at least every 3 years, review a written RM plan, which may be a component of the QM plan, that:*

(1) (proposed text unchanged)

(2) *Includes a mechanism by which the program director reports:*

(a) (proposed text unchanged)

(b) *The death of an individual, as ~~[[provided under Health-General Article, §10-714, Annotated Code of Maryland]]~~ as outlined in Regulation .14 of this chapter; and*

(3) *Tracks and evaluates incidents reported under §C(1) and (2) of this regulation and complaints filed under Regulation .16 of this chapter to determine trends.*

D. (proposed text unchanged)

.13 Reports of Death.

Upon notification of the death of any individual in a State funded or operated program or facility, the administrative head of the program or facility shall:

A. Report the death according to the provisions of Health-General Article, §10-714(a), Annotated Code of Maryland; and

B. Use the form required by the Administration.

.14—.15 (proposed text unchanged)

.16 Complaints.

A.—C. (proposed text unchanged)

D. A program shall include in the complaint process required by §A of this regulation the procedures for registering and responding to the complaints in a timely fashion, which:

(1) [[Include a specific standard, monitored by the program for compliance, directing that]] Require a complaint to be reviewed by the program and, if applicable, the CSA, within 30 calendar days of the program's receipt of the complaint;

(2)—(7) (proposed text unchanged)

E. (proposed text unchanged)

F. Unless the individual [[poses a danger]] presents a serious risk to self or others, the program shall postpone taking action until [[a final decision is made]] the recommendations of the CSA and the Administration have been made, if applicable.

.17 (proposed text unchanged)

10.21.20 Community Mental Health Programs —Outpatient Mental Health Centers

*Authority: Health-General Article, §§10-901 and 10-902,
Annotated Code of Maryland*

.06 Evaluative Services Provided.

A. (proposed text unchanged)

B. Co-Occurring Substance Abuse Screening Assessment. The face-to-face diagnostic assessment conducted under §A of this regulation shall include [[an]] a screening assessment, using a scientifically validated, and if available, age appropriate tool, to determine whether the individual has a co-occurring substance abuse disorder.

C.—D. (proposed text unchanged)

.07 Treatment Planning and Documentation.

A. Individual Treatment Plan (ITP).

(1) Initial ITP.

(a) Not later than the fifth visit after an individual is enrolled in an OMHC and based on the assessment conducted under Regulation .05B of this chapter, the treatment coordinator and the individual, ~~[[or]]~~ and if the individual is a minor, the minor's parent, guardian, or primary caretaker if appropriate, shall develop an ITP in collaboration with:

(i)—(ii) (proposed text unchanged)

(b) The ITP shall include, at a minimum:

(i) (proposed text unchanged)

(ii) The individual's presenting needs, ~~[[wants,]]~~ strengths, ~~[[and]]~~ recovery, and treatment expectations and responsibilities;

(iii) (proposed text unchanged)

(iv) A description of how the needed and desired ~~[[skills and supports]]~~ treatment will help the individual to manage the individual's psychiatric disorder and to support recovery;

(v)—(vi) (proposed text unchanged)

(c) (proposed text unchanged)

(2) (proposed text unchanged)

(3) Signature of the ITP and Reviews.

(a)—(e) (proposed text unchanged)

(f) If the individual is receiving medication prescribed through the OMHC, an OMHC psychiatrist, or Certified Registered Nurse Practitioner in psychiatry, whomever prescribes the medication, shall sign the plan and reviews.

(4)—(5) (proposed text unchanged)

B. Continuing Evaluation and Treatment.

(1) (proposed text unchanged)

(2) The treatment coordinator shall document any significant changes or events, including hospitalizations, that affect the individual's treatment.

[[2]] (3) (proposed text unchanged)

.11 Multi-Facility Programs.

A. An OMHC program that operates multiple sites shall assure that each additional site adheres to the [[requirements of this chapter]] application modification as outlined in COMAR 10.21.16.04E.

B.—D. (proposed text unchanged)

JOHN M. COLMERS
Secretary of Health and Mental Hygiene

Subtitle 21 MENTAL HYGIENE REGULATIONS

10.21.21 Community Mental Health Programs — Psychiatric Rehabilitation Programs for Adults

Authority: Health-General Article, §§10-901 and 10-902,
Annotated Code of Maryland

Notice of Final Action

[07-189-F]

On December 18, 2007, the Secretary of Health and Mental Hygiene adopted amendments to Regulation **.01**, the recodification of Regulation **.02-1** to be Regulation **.03**, the amendment and recodification of Regulations **.03—06**, and **.06-1** to be Regulations **.04—07** and **.09**, new Regulations **.08** and **.10—13**, and the repeal of existing Regulations **.07** and **.08** under **COMAR 10.21.21 Community Mental Health Programs—Psychiatric Rehabilitation Programs for Adults**. This action, which was proposed for adoption in 34:16 Md. R. 1452—1458 (August 3, 2007), has been adopted with the nonsubstantive changes shown below.

Effective Date: January 14, 2008.

Attorney General's Certification

In accordance with State Government Article, §10-113, Annotated Code of Maryland, the Attorney General certifies that the following changes do not differ substantively from the proposed text. The nature of the changes and the basis for this conclusion are as follows:

Regulation .05B(1)—(3): This revision combines two provisions regarding screening and initiation of service into the same 10 day period. This is not a burden on the provider, gives the provider more flexibility, and does not burden the consumer since much of the work of initial

intake can be done without a face-to-face screening. Placement in the right program is not based on the initial referral but on the subsequent assessment. Notice is given to the consumer and no rights are taken away. This is not a substantive revision.

Regulation .05B(1)(b): Adding the words to “determine whether rehabilitation services are medically needed by the individual” make clear that such services must address the individual's disability and mental illness. This is not a substantive revision.

Regulation .06C(4)(a)—(d) and (5): The revisions and additions in these regulations are clarifications. The addition of “ITRP” which was an unintended omission which burdens neither provider or consumer. This is not a substantive revision.

Regulation .06D(3): This new language sets forth what is already required in proper documentation of services. Any medical record must include significant changes, events, including hospitalizations that affect the individual's rehabilitation. This does not burden the provider. It gives them clear notice of what is required. This is not a substantive revision.

Regulation .07B(3)(a): Changing the language clarifies that rehabilitation is about developing skills that have been lost or are lacking as a result of a mental illness. This is what was intended. The revised language is clearer. This is not a substantive revision.

Regulation .07B(3)(g): Adding that wellness management is part of rehabilitation program services is making clear what has always been implied. Once the program works with an individual to achieve skills to cope with the individual's mental illness the program works with the individual to make sure the skills will remain. This is what is meant by wellness management. It is an integral part of the program. This language simply states underlying assumptions. This is not a substantive revision.

Regulation .07F(2): Changing the word “contact” to “to assist the individual to access” again is a clarification of the purpose of the program. The program is not to take care of the individual's needs. The program helps build skills that permit the individual to take charge of handling the individual's mental illness. This is a clarification that is understood in the field, does not burden the provider, and benefits the consumer. This is not a substantive revision.

Regulation .08B: Changing the language that states “In order to prevent the” to “For an individual at risk of an” clarifies that no provider can control any individual's behavior. Rather the provider works with the individual through developing a MIP to assist the individual in meeting the individual's treatment goals, which include not leaving the program before the goals are reached (i.e. unplanned discharge). This change does not burden the provider and it benefits the consumer by recognizing the consumer's independence. This is not a substantive revision.

Regulation .09C(2)(b): Deleting this paragraph does not burden the consumer. The program does not supply the consumer's needs. The program assists consumers in caring for their own needs, including food and household goods. This requirement is set for in COMAR 10.21.21.06C(1). This is not a substantive revision.

Regulation .10C(1): Adding the word “independently” makes clear what happens in practice now. Staff must be trained before staff can work with a consumer. This is not a substantive revision.

Regulation .11B(2)(a), C(2)(a), D(2)(c): These changes are necessary to make the citations to COMAR accurate. This is not a substantive revision.

Regulation .12A: After this regulation was published MHA discussed it with some providers. The providers believed that the language as written did not reflect practice and clarification was needed. The change reflected current practice to have an overall ratio in the on-site facility rather than just for groups. The change gives the providers greater flexibility to maintain a 1:10 ratio in order to work 1:1 with a consumer when needed and then have staff also run a group activity. The change is clarifying and benefits the consumer while giving the provider flexibility. This is not a substantive revision.

.05 Eligibility, Screening, and Initiation of Service.

A. (proposed text unchanged)

B. Screening.

[[(1)]] Within [[(5)]] 10 working days of receipt by the program of *a complete* referral for PRP services [[, staff]]:

(1) *Staff* assigned by the program director shall conduct a [[face-to-face]] screening assessment to [[:

(a) Assess the individual's:

(i) Rehabilitation services *wants and* needs;

(ii) Willingness to participate in PRP services; and

(iii) *Residential rehabilitation program (RRP) service wants and needs, when appropriate; and*

(b) Determine the program's ability to address the *wants and* needs identified in §B(1)(a)(i) and (iii) of this regulation]] determine whether rehabilitation services are medically needed by the individual.

(2) If, following the screening assessment under §B(1) of this regulation, the program director determines that the program's services are not appropriate for an individual who has been referred, the program director shall, in writing [[, promptly]]:

(a)—(c) (proposed text unchanged)

(3) [[Within 5 working days of the screening assessment conducted under §B(1) of this regulation, unless]] *Unless* the program director has notified the individual of the determination under §B(2) of this regulation, the program director shall notify the individual whether the program:

(a)—(c) (proposed text unchanged)

(4) (proposed text unchanged)

C. (proposed text unchanged)

.06 Evaluation and Planning Services.

A.—B. (proposed text unchanged)

C. Individual Rehabilitation Plan (IRP).

(1)—(3) (proposed text unchanged)

(4) Signature of the IRP or ITRP and Reviews.

(a) The following shall sign that they agree with the IRP [[and]] or ITRP and reviews:

(i)—(ii) (proposed text unchanged)

(b) With proper consent, family or others designated by the individual, including the individual's caregivers, may sign the IRP [[and]] or ITRP and reviews.

(c) If the individual is unwilling to sign agreement with the IRP [[and]] or ITRP and reviews, the individual's rehabilitation coordinator shall:

(i) Verify the individual's verbal agreement with the IRP [[and]] or ITRP and reviews; and

(ii) (proposed text unchanged)

(d) In addition, for an ITRP, at least two licensed mental health professionals, who collaborate about the individual's treatment, shall sign the [[IRP]] ITRP and ITRP reviews, including:

(i)—(ii) (proposed text unchanged)

(5) Upon completion of an IRP [[or]], ITRP, or review, an individual's rehabilitation coordinator shall assure that the individual is offered a copy of the plan or review and document the individual's receipt or decline of the offer in the individual's medical record.

D. Continuing Evaluation.

(1)—(2) (proposed text unchanged)

(3) If not documented in §D(1) or (2) of this regulation, the rehabilitation coordinator shall document any significant changes or events, including hospitalizations, that affect the individual's rehabilitation.

[[3]] (4) (proposed text unchanged)

.07 Rehabilitation and Support Services Provided.

A. (proposed text unchanged)

B. Rehabilitation *and* Recovery Activities.

The program director shall ensure that the program provides rehabilitation activities directed toward the *individual's recovery and the improvement or restoration* of skills, including:

(1)—(2) (proposed text unchanged)

(3) Independent living skills, including:

(a) [[Maintenance of the individual's living environment]] Skills necessary for housing stability;

(b)—(d) (proposed text unchanged)

(e) Accessing available entitlements *and resources*; [[and]]

(f) (proposed text unchanged)

(g) Wellness self-management; and

(4) (proposed text unchanged)

C.—E. (proposed text unchanged)

F. *On-Call and Emergency Response. The program director shall assure that:*

(1) (proposed text unchanged)

(2) *All relevant staff shall [[contact]] assist the individual to access, as appropriate, the OMHC, mobile crisis, residential crisis services, hospitals, and other service providers that are designated to provide crisis and emergency care and treatment.*

G. (proposed text unchanged)

.08 Residential Rehabilitation Program (RRP) Managed Intervention Plan (MIP).

A. (proposed text unchanged)

B. ~~[[In order to prevent the]]~~ *For an individual at risk of an unplanned discharge* ~~[[of an individual]]~~, the rehabilitation coordinator, in collaboration with the individual, shall prepare a MIP that includes:

(1)—(2) (proposed text unchanged)

C. (proposed text unchanged)

.09 Supported Housing Services for Adults.

A.—B. (proposed text unchanged)

C. Accessing and Sustaining Housing. The program director shall ensure that the program provides, as needed by and acceptable to the individual, services that are directed at:

(1) (proposed text unchanged)

(2) Developing or restoring appropriate basic living skills and supports to keep housing, such as:

(a) (proposed text unchanged)

~~[[b) Maintenance of an adequate supply of food and household goods;]]~~

~~[[c)]] (b)—~~[[e)]] (d)~~~~ (proposed text unchanged)

(3) (proposed text unchanged)

.10 Staff Qualifications and Responsibilities.

A.—B. (proposed text unchanged)

C. Psychiatric Rehabilitation Direct Care Staff. The program shall employ psychiatric rehabilitation direct care staff who:

(1) Have 40 hours of PRP training before independently providing PRP services;

(2)—(3) (proposed text unchanged)

.11 Required Program Staff.

A. (proposed text unchanged)

B. If a PRP has fewer than 30 enrollees, the PRP shall employ either:

(1) (proposed text unchanged)

(2) *A program director who is responsible for the duties of the program director and the duties of a psychiatric rehabilitation specialist, if the program director:*

(a) *Has the qualifications described under ~~[[Regulation .11B(1)(a)]] Regulation .10B(1) of this chapter;~~*

(b)—(c) (proposed text unchanged)

C. If a PRP has 30—100 enrollees, the PRP shall employ either:

(1) (proposed text unchanged)

(2) *A program director who is responsible for the duties of the program director and the duties of the psychiatric rehabilitation specialist, if the program director:*

(a) *Has the qualifications described under ~~[[Regulation .11B(1)]] Regulation .10B(1) of this chapter;~~*

(b)—(c) (proposed text unchanged)

D. If a PRP has more than 100 enrollees, the PRP program shall employ:

(1) (proposed text unchanged)

(2) *A psychiatric rehabilitation specialist or specialists and staff assigned to administrative duties as follows:*

(a)—(b) (proposed text unchanged)

(c) *If the program director has the qualifications described under ~~[[Regulation .11B(1)]] Regulation .10B(1) of this chapter:~~*

(i)—(ii) (proposed text unchanged)

.12 Ratio.

A. The program shall maintain an average ratio of at least one rehabilitation staff member serving each ten individuals who are receiving ~~[[group]] on-site PRP services, [[either at the PRP facility or off-site]] or receiving off-site PRP services in a group.~~

B. (proposed text unchanged)

JOHN M. COLMERS
Secretary

