## State of Minnesota Criteria for Adult Mental Health Case Managers

1. A case manager with 2000 hours or more supervised experience in the delivery of mental health services must receive 38 hours per year of ongoing supervision and clinical supervision. The 38-hourI requirement is met with:
   1. At least one hour per month (12 hours/year) must be clinical supervision regarding individual service delivery with a case management supervisor.
   2. The remaining 26 hours of supervision may be provided by a case manager with two years of experience.
2. A case manager without 2000 hours of supervised experience in delivery of services to adults with mental illness must receive the following:
   1. One hour per week of clinical supervision regarding individual service delivery from a mental health professional until 2000 hours experience are met.
   2. Must complete 40 hours training approved by DHS in case management skills and characteristics, and needs of adults with SPMI or children with SED.
   3. A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours continuing education and training in mental illness and mental health services every two years.
3. Group supervision may not constitute more than one-half of the required supervision hours.
4. Clinical supervision related to a recipient must be documented in the recipient’s record.

## State of Minnesota Criteria for Case Management Services (SPMI)

“Serious and persistent mental illness” means the condition of an adult who has a mental illness [ICD-9 - CM) current edition, code range 290.0 to 302.99 or 306.0 to 315.0 or the corresponding code in DSM-4] and meets at least one of the following criteria:

1. The adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;
2. The adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;
3. The adult has been treated by a crisis team two or more times within the preceding 24 months;
4. The adult:
5. has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder; and
6. indicates a significant impairment in functioning; and
7. has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in item 1 or 2 unless an ongoing case management or community support services are provided;
8. The adult has, in the last three years, been committed by a court as a mentally ill person under Minnesota Statutes, Chapter 253B, or the adult’s commitment has been stayed or continued;
9. The adult:
10. was eligible under clauses 1 to 5, but the specified time period has expired or; the adult was eligible as a child under Minnesota Statutes 245.4871, Subd. 6.; and
11. has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment of a frequency described in clause 1 or 2 unless ongoing case management or community support services are provided.

## Differentiation of Case Management, CSP and ARMHS Services

### *Targeted Case Management (TCM)*

This service includes face-to-face contact between the case manager and the client, or between the case manager and the client’s family, legal representative, primary care giver, mental health providers, etc. It would also include telephone contacts between case manager and any of those listed above. Other case management services include contacts between the case manager and supervisor concerning the client, and development, review and revision of the ICSP and Functional Assessments. We expect the case managers to make at least one targeted case management “hit” per month per client.

Case management duties include building the relationship with the client – conveying positive regard, cheerful demeanor, accurate affect, organized atmosphere, etc. It also involves collaboratively creating and reviewing the Functional Assessment and Individual Community Support Plan (ICSP) as well as monitoring clients’ achievement of specific goals created in the ICSP and evaluating the clients’ general progress. Another duty is assisting the client with applications, forms, paperwork items that could be barriers to progress.

*Case Management is:*

* Assisting clients to obtain needed services
* Coordinating with other agencies to obtain services for clients
* Completion and review of functional assessment
* Participation in case conferences, administrative reviews, client staffing and informal conferences
* Development of goals, plans, agreements
* Routine contacts (monthly at a minimum)
* Other monitoring or communication with the client, family members, other relevant persons regarding status of client, individual service plan or progress in achieving goals of service plan
* Receiving clinical supervision regarding an identified client with SPMI
* All planning, assessments, record keeping and documentation associated with service coordination of the case
* Assessment and evaluation of service effectiveness
* Communicating about the status of the recipient in achieving the goals of the service plan
* Participating and monitoring facility discharge planning
* Arranging transportation, child care, etc. to enable client to participate in arranged services
* Assisting recipients to obtain and keep health coverage

*Case Management is NOT:*

* Treatment or therapy
* Case management provided under a waiver
* Legal advocacy
* Medication administration, management or monitoring
* Skills work
* Transportation Service (if the case manager is needed at the appointment transportation can be provided)

*Types of Case Management Contact:*

* *Face-to-Face Contact (may be referred to as a “hit”):* This is for a direct, face-to-face meeting with the client or their legal representative (guardian). A face-to-face contact with every client is required no less than one time every three (3) months. This is figured into the case manager’s productivity and is billed.
* *Non-Billable Contact with Professional:* This includes meeting with or a telephone conversation with a professional regarding the client. Professionals would include the psychiatrist, therapist, Department of Rehab Services Worker, Cedar Valley Services, etc. Consultation between a case manager and their supervisor regarding the client would fit in this category. This is figured into the case manager’s productivity, but ***cannot*** be billed. A case note is completed for these contacts see agency policy for how to enter notes.
* *Telephone Contact:* This is for telephone contact with the client and/or their legal representative (guardian). A case manager can only connect with a client via telephone for two (2) consecutive months before a face-to-face contact is required. This is figured into the case manager’s productivity and is billed for up to two (2) consecutive months. A TCM Phone Contact note is completed for all calls with a client. Figure the time into the Face-to-Face with a client, and note the amount of travel time in the Progress Note.
* *Travel Time:* This is figured into the case manager’s productivity, but cannot be billed.
* *Non-Billable Contact with Other:* This includes meeting with or a telephone conversation with a client’s family member, landlord, significant other, friend, other concerned person, etc. This is figured into the case manager’s productivity, but ***cannot*** be billed. A TCM note is completed for these contacts.
* *Face-to-Face Contact:* This is for a direct, face-to-face meeting with the client or their legal representative (guardian). A face-to-face contact with every client is required no less than one time every three (3) months. This is figured into the case manager’s productivity and is billed. A TCM Progress Note is completed for every direct face-to-face contact with a client.
* *Non-Billable Contact with Professional:* This includes meeting with or a telephone conversation with a professional regarding the client. Professionals would include the psychiatrist, therapist, Department of Rehab Services Worker, Cedar Valley Services, etc. Consultation between a case manager and their supervisor regarding the client would fit in this category. This is figured into the case manager’s productivity, but ***cannot*** be billed.
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* *Travel Time:* This is figured into the case manager’s productivity, but cannot be billed.
* *Non-Billable Contact with Other:* This includes meeting with or a telephone conversation with a client’s family member, landlord, significant other, friend, other concerned person, etc. This is figured into the case manager’s productivity, but ***cannot*** be billed.

# Documentation Requirements

**Electronic Health Record**

All documentation is completed in SSIS or other EHR systems per your agency policy and procedures. It is important to understand your agencies technology to efficiently enter notes. See examples given of SSIS documentation for county workers.

## TCM Progress, Chart, Phone, and/or Face to Face contacts.

**TCM Progress Notes**

You may be asked to document your time in a specific format. Please check with your supervisor for their preferred method of documentation. Included are possible formats to help organize your progress notes from client interactions. Please note that all formats consider the following:

* A Progress Note is a legal document and must be legible, clear and specific.
* Record of *each* occurrence of a service – to who, date, type, clock time, summary, response.
* Must have the name of the person who provided the service – signature and title.
* Completed after every face-to-face contact with a client and/or guardian.
* Proper Progress Notes allow anyone to pick up the file, review it and clearly know what has been done, what is currently being worked on and what is to be worked on in the future.
* “Billable time” is only the face-to-face or phone contact with a client or guardian/conservator.
  + Collateral contacts with other concerned persons are NOT counted for billing, but does figure into productivity.
  + If you are billing as Case Management, you *must* have performed a Case Management service.
    - Assessment Process (Functioning Impairment, including Physical Health)
    - Developing ICSP or Sixth Month Progress Review
    - Referral and Related Activities to Obtain Needed Services
    - Monitoring of Services and Follow up Activities
    - Meetings with Client and Non-Eligible Participants
* Bill in 15-minute increments. *ROUND ACCURATELY*: 20 minutes of contact does not equal 1 hour of contact time!

### Writing a Good Progress Note

* Core questions to answer in Progress Notes:
  + What category of services were provided (e.g., Assessment, Planning, Referral, Monitoring)?
  + What goal/objective from the ICSP were you working on?
  + How did the client respond?
  + What was the outcome of the service?
  + How is the client generally responding to service efforts (e.g., progressing, maintaining, regressing)?
  + What are the next steps (e.g., plan for next contact, new service needs identified)?
  + What services have been requested by client, what services are not available to the client, what are client’s unmet needs?
* Every Targeted Case Management Progress Note must answer the following questions:
  + Who participated in the meeting?
  + What specific goal or goals were addressed in this meeting?
  + What resource(s) were discussed and what was the result?
  + How did the client respond in this meeting?
  + Clinical observations noted?
  + What are the steps prior to the next meeting?
* Complete in the 3rd Person: refer to yourself as “This Writer”
* Refer to the client as “client” and other persons involved as to what their relationship is with the client – “client’s parent”, “client’s spouse”, “client’s friend”, etc.
* Missed scheduled appointments must be documented. You can utilize the “attempted” button to document this in SSIS.

### Common Progress Note Mistakes:

* Narrative is not clearly related to the ICSP.
* No specific service described.
* Does not indicate next steps or plan for next contact.
* Too much or too little information.
* Only documents symptoms/functioning.
* Use clinical language, jargon, or terms which are not descriptive or unique to the client (e.g., stable, depressed, anxious, manic, etc.). What are the client’s *specific* symptoms?
* Judgmental, subjective, or vague descriptions (“appropriate”).
* No continuity from contact to contact.
* Repetition from contact to contact.
* No evaluation if service is working or should be changed.
* No links to ICSP goals and objectives.

**Example of Documenting “Progress”:**

* Not so good: “Carlos is making appropriate progress.”
* Good: “Carlos is now able to initiate calm conversations independently with minimal prompting during 6 of 10 conversations.”
* Good: “Carlos has reduced his use of angry profanity from every conversation to less than once every 3 conversations since services began.”

**SIRP format**

S.I.R.P. is an acronym for:

* Situation
* Intervention
* Response
* Plan

**Situation**

The Situation: Use a clear and complete notation or description regarding the client’s current complaint(s), condition(s), assessment of client and/or reason(s) presented during the session. Use behavioral terms, and include an assessment of the client. This is not a statement of diagnosis but rather a statement of why this session was necessary.

* Observation of client’s presentation at time of service, e.g. hygiene, speech, mood, etc.
* What impairments are the focus?
* Is the diagnosis still valid?
* Is progress being made?

**Intervention**

The Intervention: Use descriptive sentence(s) about staff’s interventions (what you did). Identify skills used to cope/adapt/respond/problem solve. Reinforce new behaviors, strengths. Identify specific skills that are taught/modeled/practiced. The intervention elements of the progress note shall describe the following:

* Clinician’s interventions: what did clinician do?
* Clinician’s assessment, including risk assessment when applicable
* Document advice/recommendations given to client/family

**Response**

The Response of the Client to Staff Intervention: Use descriptive sentences about the client’s response to the staff’s intervention; describe the response to the intervention in behavioral terms and include the client’s progress or lack of progress. Can also include general response to treatment. Response may also include a description of how the client received the intervention.

* Any new Assessment findings
* Is there progress or a lack of improvement – explain latter
* Did client understand, accept, intervention or appear resistant?
* Explain the need for additional treatment due to Medical Necessity
* Include outcome measures in documentation, as appropriate.
* Brokerage service responses may include response from agency that was being linked to.
* In instances where there is no direct contact with client or agency, response can be
* deferred to following note.
* Response from agency receiving referral, linkage, coordination

**Plan**

The Plan: The Plan component outlines clinical decisions regarding the client, collateral contact, referrals to be made, follow-up items, homework assignments, treatment meetings to be convened, etc. Any referrals to community resources and other agencies when appropriate, and any follow-up appointments may also be included.

* Are new goals needed?
* Document that the treatment goals remain appropriate, or revise as needed.
* If lack of improvement, obtain a consultation to verify the diagnosis or consider change
* in treatment strategy
* Consider treatment titration and plan for discharge.

**DA(R)P format**

DA(R)P is an acronym for:

* Data
* Assessment and Response
* Plan

**Data**

The data: Data, in this format, includes both subjective and objective data about the client as well as the therapist’s observations and all content and process notes from the session.

* Observation of client’s presentation at time of service, e.g. hygiene, speech, mood, etc.
* What impairments are the focus?
* Who was involved, where, and when a significant event occurred.
* Description of an issue of personal importance discussed by the client and how they experienced the event.

**Assessment and Response**

The assessment and response: The Assessment and Response includes your clinical impressions, hunches, hypotheses, and rationale for your professional judgment. Progress is also noted here.

* How the event or behavior relates to precipitating factors, to previous behavior, to other events in the client’s life, to the treatment plan.
* Assessment may also record your observations about the client’s physical or emotional state and such factors as severity of symptoms, riskiness of behavior, dangerousness, suicidality and so forth
* Information given to client, a homework assignment, a challenge to narrow thinking about an issue, formal problem solving around the event, empathetic/supportive behavior on your part, functional analysis of a situation, a normalizing comment.
* If the situation is a serious one involving detailed assessment of danger or legal issues, you would document what you did in whatever detail is necessary to show that you attended to the issues involved.

**Plan**

The Plan: The Plan component outlines clinical decisions regarding the client, collateral contact, referrals to be made, follow-up items, homework assignments, treatment meetings to be convened, etc. Any referrals to community resources and other agencies when appropriate, and any follow-up appointments may also be included.

* Are new goals needed?
* Document that the treatment goals remain appropriate, or revise as needed.
* If lack of improvement, obtain a consultation to verify the diagnosis or consider change
* in treatment strategy
* Consider treatment titration and plan for discharge.

**TCM Phone Contact**

A TCM Phone Contact note is completed after every telephone conversation with a client or their Guardian. Phone contacts with a client or guardian if there has been a face-to-face contact documented within the past three months. The Phone Contact note should describe what was discussed and any plans made. Phone contacts are documented and billed in 15-minute increments.

**Text Messaging:** It may be recommended text messaging not be used with clients due to the difficulty controlling confidential information. However, given at times clients will have not minutes left on their phone, but may have unlimited texting, the occasion may arise where it is needed. Text messaging should be used sparingly and kept very brief, for example “Running late, be there in 5 minutes” and reveal no identifying information. *Text messages are not billable nor figured into productivity.* If something from a text message needs to be documented, please complete A TCM Note. Please check with your individual agency surrounding if texting can be utilized.

**Email**: Please check with your individual agency surrounding if email can be utilized as a method to contact clients. If using email, please see attached document for an example of a consent agreement.

**Facebook Messenger:** Please check with your individual agency surrounding if email can be utilized as a method to contact clients.

**TCM Note**

A TCM Note is completed for collateral contacts with other providers, concerned persons, etc. The Note is also completed when you completed something for the client (CSP Activity), but they were not present.

## LOCUS, Functional Assessment & Individual Community Support Plan

### LOCUS

The Level of Care Utilization System (LOCUS) was created by the American Association of Community Psychiatrists. It is a tool used to guide assessments, determine level of care recommendations and to support admission, continued stay and discharge from mental health facilities. It is a system that evaluates the current status of clients and their needs based on six evaluation Dimensions:

1. Risk of Harm
2. Functional Status
3. Medical, Addictive and Psychiatric Co-Morbidity
4. Recovery Environment: Stress & Support
5. Treatment and Recovery History
6. Engagement

The LOCUS is a methodology for quantifying the assessment of service needs in order to reliably place a client into the service continuum. The levels of care are flexible and describe resources and intensity, not programs and are adaptable to any continuum of care. It measures both psychiatric and addiction problems as well as their impact on the client. The LOCUS does not tell you how to design programs, specify treatment interventions, negate clinical judgment or limit creativity. It acts as a guide for treatment planning.

*Due to copyright laws, the LOCUS must be completed using the paper form from Minnesota Department of Human Services. Once completed and all signatures obtained, follow your agency policy on filing or uploading.*

### Functional Assessment (FA)

Prior to development of a plan (ICSP), the case manager must complete a Functional Assessment on the client. Therefore, they are to be completed every 180 days, or 90 days upon written request of the client or client’s family to have it completed every 90 days.

A Functional Assessment is an assessment by the case manager of the client’s:

* Mental health symptoms as presented in the client’s diagnostic assessment
* Mental health needs as presented in the client’s diagnostic assessment
* Use of drugs and alcohol
* Vocational and educational functioning
* Social functioning, including the use of leisure time
* Interpersonal functioning, including relationships with the adult’s family
* Self-care and independent living capacity
* Medical and dental health
* Financial assistance needs
* Housing and transportation needs
* Other needs and problems.

The narrative section of the Functional Assessment must include for each domain:

* Status – just the facts. When considering status, ask yourself “what is it I know through the data”. It is more about “what is”, for example noting a client has “cognitive deficits”.
  + Status can imply some judgment, but be careful of projected values.
* Functioning – Function is more about “how”. What does this look like for the client? When considering function, ask yourself and the client who, what, when, where, why, how. Those questions lead you to the description of how a person is functioning. For example, for someone with the status of “cognitive deficits” you might put something like “the client has difficulties focusing and paying attention and forgets what they were doing. They write things in a notebook as an adaptation and this has been useful.
  + Function is more value neutral, it either serves the purpose or it doesn’t, and the client defines the purpose.
* Link to the Mental Illness (If there is one) – how does all of this link to their mental illness diagnoses? For example, the individual with cognitive deficits may have Major Depressive Disorder and the cognitive deficits are the result of receiving Electroconvulsive Therapy.

The Functional Assessment must note both the positives and the areas of improvement for the client in each of the categories. Additionally,

* Functional Assessments must be signed by the case manager with their proper credentials (John Doe, BA; Jane Smith, LSW; etc.) and also signed off by a Mental Health Professional (Program Manager).
* The Program Manager then gives the Functional Assessment to the Program Assistant who logs the completion on the Case Manager’s Paperwork Spreadsheet – found on the Shared Drive. It is then filed in the Case Management File.

**How to Write an Interpretive Summary**

The interpretive summary is used to synthesize the information obtained from the three-tier assessment process (diagnostic, functional and LOCUS) to prioritize direction for the upcoming individual treatment plan. It is an essential bridge or link from assessment to service planning.

An interpretive summary does the following:

• Identifies what outcomes the person desires relative to his or her life circumstances and preferences

• Describes how the mental health symptoms are affecting the person’s and his or her family’s life

• Summarizes the nature of the functional barriers as they relate to symptoms of the mental illness to establish the priorities for the next treatment plan

• Examines the person’s strengths, abilities and resources

• Examines how the person’s strengths, abilities and resources can be engaged to improve functioning and move forward on identified desirable recovery outcomes

• Establishes the priorities for the initial and subsequent individual treatment plan

• Recommends services and interventions

The mental health clinical supervisor or mental health practitioners under the supervision of the mental health professional clinical supervisor must complete the interpretive summary. The mental health professional and mental health practitioner must sign the interpretive summary.

**Example 1: What’s Missing?**

Janet, 58 years old, diagnosed with major depression, recurrent, with psychotic features, has spent the last 20 years institutionalized either in the hospital or a nursing home. She moved into a supported apartment last month. She has a complicated medical regimen because of high blood pressure, obesity, and cardiac insufficiency. She presents as clean but is disheveled and has on multiple layers of clothes on a hot summer day. Refer her to ARMHS.

**Example 2: Better Interpretive Summary**

Janet, 58 years old, diagnosed with major depression, recurrent, with psychotic features, has spent the last 20 years institutionalized either in the hospital or a nursing home. She moved into a supported apartment last month. She has a complicated medical regimen because of high blood pressure, obesity, and cardiac insufficiency. She is happy to be out of nursing home, eager to make friends and live more independently, but anxious because she has not been responsible for taking care of herself for a long time. She is not yet connecting her needs with her illness, attributing them primarily to lack of services that the nursing home staff provided her. Her depression and sometimes tenuous reality testing make it difficult for her to learn complex skills and grasp complex concepts without extensive support and repetition. ARMHS services can assist Janet by providing structure and support. Highest priority skill development areas include maintaining at least a minimal energy level through illness self-management, maintaining her physical health, developing basic food preparation and living space management skills, and developing recovery goals for her life outside of an institution.

*Please see “Things to Consider When Completing the ICSP and FA” below.*

### Individual Community Support Plan (ICSP)

The case manager provides services for persons with a serious and persistent mental illness. A case manager links the client to needed services and provides emotional support as well. Each client and their Case Manager develop an Individual Community Support Plan which reflects personal strengths, needs and goals.

The case manager must develop an Individual Community Support Plan for each adult that incorporates the client's Individual Treatment Plan, if there is one. The Individual Treatment Plan may not be a substitute for the development of an ICSP. The ICSP must be developed within 30 days of client intake and reviewed at least every 180 days after it is developed, unless the case manager receives a written request from the client or the client's family for a review of the plan every 90 days after it is developed. The case manager is responsible for developing the individual community support plan based on a diagnostic assessment and a functional assessment and for implementing and monitoring the delivery of services according to the individual community support plan. To the extent possible, the adult with serious and persistent mental illness, the person's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual or family community support plan.

* The ICSP is a written plan of action developed by a case manager and the client based on diagnostic and functional assessments which identify specific service needs by the adult with SPMI, and must state:
  + Goals and objectives of treatment – the goals of each service
  + Treatment strategy – the activities for accomplishing each goal
  + A schedule for accomplishing treatment goals and objectives, and
  + The individual responsible for providing treatment to the adult.
  + The frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the ICSP.
* The strengths/resources and barriers/areas of improvement must be listed for each, as needed.
* The case manager works with the client to develop an ICSP.
* Completed every 6 months, or sooner if requested in writing from the client’s family/guardian or the case manager recognizes a significant change in functioning.
* Goals are reviewed and updated as needed at each interaction with the client.
* The ICSP should be outcome oriented:
  + Be done with a focus on the whole person including strengths
  + List 2-3 mutually identified goals and services to address them
  + Stipulate outcomes to be achieved
* ICSPs must be signed by the case manager with their proper credentials (John Doe, BA; Jane Smith, LSW; etc.) and also signed off by a Mental Health Professional (Clinical Supervisor).

#### Goals and Goal Writing

Since it is the client’s ICSP, they must be completed *with* the client. The most successful treatment plans/ICSPs are ones in which the client has input and the goals are theirs. It must be clear on the ICSP what the goals are. One way to look at it is that anyone should be able to pick up an ICSP and know very clearly what is being worked on and how the client and case manager will know if and when the goal is met. Some things to keep in mind while writing an ICSP:

* It must be clear what the goal is, what the steps are and who is responsible for the steps.
* All goals must be measurable – how will you and the client know if/when the goal is achieved?
* If the client has a difficult time coming up with a measurable goal, work with them on what specifically they want to work on through open-ended questions. Then a good question to ask them, “In six months when we write a new ICSP, how will we know if you achieved this goal – what will be different?”
* *Keep it short* – a couple of goals that get accomplished are better than a long list that does not.
* *See Appendix B for additional resources on goal writing.*

### Things to Consider When Completing a FA and ICSP

* General Mental Health Needs: the principle therapeutic issues in the person’s life. These can be found in the Diagnostic Assessment.
  + Understanding and Accepting my Illness: Does the client have enough information about their diagnosis and do they accept the diagnosis at this time?
  + Managing my Symptoms: What symptoms does the client have and does the client have coping skills to manage the symptoms effectively.
* Daily Living Activities
  + Personal Hygiene: Can the client complete hygiene tasks independently?
  + Keep Room, Apartment or House Clean: Can the client keep their environment clean and healthy or does the client need assistance from a home health aide, private housekeeper, etc.? Case managers assist in finding services for clients and may need to assist in cleaning at times.
  + Buying and Preparing Health Foods: Does the client have a basic understanding of the food groups and what is needed to maintain a healthy diet? Case Managers will refer to patient education and/or a dietician if needed.
* Transportation: Does the client have their own vehicle with insurance or is the client in need of information about public transportation options in their hometown? We refer the client to use their families/friends, SCAT Bus, taxi, volunteer drivers, R & S Transportation, etc. *It is of utmost importance that the client be as independent as possible. If all of these options are unavailable, case managers then transport to medical and mental health appointments.*
* Vocational/Educational:
  + Does the client have the necessary education (GED, diploma, etc.) to obtain and maintain employment?
  + What is the client’s work history? Would the client be better served by competitive employment or a sheltered work environment?
  + Case Managers make referrals to Department of Rehabilitation to assist with employment.
  + Case Managers make referrals to Tri-County to help with employment skills and assistance with maintaining employment.
* Social Functioning: Is the client involved with people and activities that enhance their life and make good use of their leisure time? If a client does not, Case Managers can refer to activities such as Groups at the Sage Enrichment Center, community education, etc.
* Interpersonal Relationships:
  + Self: Is the client able to make reasonable decisions and plan for the future? Do they advocate for themselves and express opinions appropriately? Do they manage their feelings effectively? If not, do they need a referral to a therapist or can the Case Manager assist with developing strategies with the client?
  + Others: Is the client generally happy with their relationships with others, such as spouse, partner, friends and coworkers? If not, what services are available that would enhance the client’s relationships?
* Family relationships:
  + Does the client have the necessary parenting skills?
  + Does the client have appropriate family involvement or does the client have a too strong dependency on the family?
  + Is the client willing to let their family be supportive?
* Financial Management:
  + Case Managers do basic money management. If the client has concerns with large debts, case managers refer clients to consumer credit counseling services.
  + Is the client receiving the benefits they are entitled to? For example, does the client qualify for Social Security benefits and what assistance do they need to obtain these benefits? A referral to Disability Specialists may be warranted.
* Physical Health: Is the client physically healthy or are they in need of medical attention?
  + Is the client getting the appropriate amount of sleep?
  + Does the client get the appropriate amount of exercise?
* Medication Monitoring:
  + Does the client have concerns with medication usage? Observing the positive and negative symptoms and changes that occur in the client. Do the client and family understand the medications and their side effects? Is the client medication compliant?
  + Case Managers CANNOT distribute medications. If a client is unable to take medications appropriately or they cannot accurately fill a weekly medication box, a referral is often made to the county public health office or agency nursing service.
* Housing: Does the client have an appropriate living environment? Case Managers assist clients with providing the names of housing options and funding assistance programs for which they may qualify. The case manager then assists with filling out the necessary paperwork as needed.
* Chemical Use: Is the client chemically dependent and are they in need of a Rule 25 Assessment? Are they in treatment or do they need a referral?
* Legal Issues: Does the client have any legal issues with which they need assistance? Is the client on probation and have strict guidelines to follow?

## Diagnostic Assessment (DA)

To be eligible to receive Case Management services, a person must receive a Diagnostic Assessment from a qualified Mental Health Professional. "Diagnostic assessment" means a written summary of the history, diagnosis, strengths, vulnerabilities, and general service needs of an adult with a mental illness using diagnostic, interview, and other relevant mental health techniques provided by a mental health professional used in developing an individual treatment plan or individual community support plan. This assessment must include the components specified in the Minnesota Comprehensive Mental Health Act. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, only updating is necessary. "Updating" means a written summary by a mental health professional of the adult's current mental health status and service needs. If the adult's mental health status has changed markedly since the adult's most recent diagnostic assessment, a new diagnostic assessment is required.

To maintain case management services, a new Diagnostic Assessment needs to be completed every three (3) years or after a significant change.

The DA must contain documentation of the components listed on the site below.

[Diagnostic Assessment](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_163297)

Other TCM Documentation

**County of Financial Responsibility**

County of financial responsibility has the meanings in the following paragraphs.

* For an applicant who resides in the state and is not in a facility described in subdivision 6, it means the county in which the applicant resides at the time of application.
* For an applicant who resides in a facility described in subdivision 6, it means the county in which the applicant last resided in nonexcluded status immediately before entering the facility.
* For an applicant who has not resided in this state for any time other than the excluded time, and subject to the limitations in section 256G.03, subdivision 2, it means the county in which the applicant resides at the time of making application.
* For an individual already having a social service case open in one county, financial responsibility for any additional social services attaches to the case that has the earliest date of application and has been open without interruption.
* Notwithstanding paragraphs (b) to (e), the county of financial responsibility for semi-independent living services provided undersection 252.275, and chapter 245D, is the county of residence in nonexcluded status immediately before the placement into or request for those services.

## Client Transfers

Please utilize the TCM transfer form for any individual that is relocating to another county in the state and is going to be establishing TCM services with a new provider. See the form in the link below:

[TCM Transfer Form](https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6063-ENG)

When a client is moving to another county please note the following:

1. Effect of moving.
   * Except as provided in 4, a person who has applied for and is receiving services or assistance under a program governed by chapter 256G, in any county in this state, and who moves to another county in this state, is entitled to continue to receive that service from the county from which that person has moved until that person has resided in nonexcluded status for **two full calendar months** in the county to which that person has moved.

1. Transfer of records.
   * Before the person has resided in nonexcluded status for two calendar months in the county to which that person has moved, the local agency of the county from which the person has moved shall complete an eligibility review and transfer all necessary records relating to that person to the local agency of the county to which the person has moved.
2. Continuation of case.
   * When the case is terminated for 30 days or less before the recipient reapplies, that case remains the financial responsibility of the county from which the recipient moved until the residence requirement in subdivision 1 is met.
3. Social service provision.
   * The types and level of social services to be provided in any case governed by this chapter are those otherwise provided in the county in which the person is physically residing at the time those services are provided.

## Tardive Dyskinesia (TD) Screen

Tardive dyskinesia is a disorder that involves involuntary movements, especially of the lower face. Tardive means "delayed" and dyskinesia means "abnormal movement." Symptoms of tardive dyskinesia include facial grimacing, jaw swinging, repetitive chewing, tongue thrusting, etc.

Tardive dyskinesia is a serious side effect that occurs when one takes neuroleptic/antipsychotic medications. It occurs most frequently when the medications are taken for a long time, but in some cases it can also occur after you take them for a short amount of time.

If diagnosed early, the condition may be reversed by stopping the drug that caused the symptoms. Even if the antipsychotic drugs are stopped, the involuntary movements may become permanent and in some cases may become significantly worse.

For those clients taking psychotropic medications, the State of Minnesota requires a Tardive Dyskinesia Screening be done every year by their psychiatrist or clinical nurse specialist. This must be contained in the client file.

## Releases of Information (ROI)

In the United States, HIPAA and State guidelines strongly direct the rules and regulations of patient information. ROI departments perform such tasks as obtaining patient consent, certifying medical records, and deciding what information can be released. Before any information can be disseminated regarding a client in any way (verbally, written, etc.) to someone other than the client, a Release of Information needs to be filled out and signed by the client or their Guardian/Authorized Representative. Releases of Information can be of duration no longer than one (1) year and need to be completed at least annually.

Generally, we must get a signed release form from our clients and other individuals from whom we collect protected information before we can share that information with others.

The release form must:

* Identify the information to be shared.
* Identify with whom the information may be shared.
* Indicate how long it will be in effect.
* Indicate that permission for release can be withdrawn at any time by the individual when they request it in writing.

You should not release protected information if the release form does not contain all of these elements. Follow the procedure in your area relating to releasing information.

Four general situations where a signed release form must be obtained are described   
below.

* When you anticipate sharing health care information with others.
* When completing workers' compensation forms on behalf of injured persons.
* Before sharing protected information to insurance companies.
* Before sharing protected information with anyone other than the individual about whom the information was collected, *unless* it is authorized by law.

"Legally authorized" or "authorized by law" means as permitted or required:

* By state or federal statutes and regulations.

And/or

* By warrants, summons, subpoenas, or other court orders from a court or other authorized body, such as a grand jury, a governmental or tribal inspector general, or an authorized administrative body.

**Important** – Whether you can or should release protected information when you receive a subpoena or other type of court order depends on the situation and the procedures used in your area.

**Follow the procedures used for releasing information when you receive a subpoena or other type of court order.**

**Exceptions:** Here are five situations where the law may permit you to share protected information with others without a signed release form:

1. When you are sharing information within the welfare system as a part of providing services for the client.
2. When protected health information is shared within the same health provider system for treatment, payment, or operations (administrative functions), for example, between a state or county hospital and an associated health clinic.
3. Where an individual's health or safety is in danger.
4. To assist law enforcement in pursuing a fleeing felon.
5. When maltreatment of a minor or vulnerable adult is suspected.

**Practices that comply with the Minimum Necessary Rule**

* Discuss an individual’s case **only** as needed to do your job.
* Whenever possible, limit your review of an individual’s records to information required to do your job.
* When doing database searches for information on an individual, use search words that would limit your results to what you are looking for.
* When you hear of a celebrity or "high profile" case, do not search for or access that case unless it is assigned to you.
* Do not look up information about family members, ex-spouses, friends, neighbors, acquaintances, yourself, or anyone else whose case is not assigned to you.
* Ask to be re-assigned if you are given a case that involves an ex-spouse, family member, friend, acquaintance, or yourself.
* Where the law permits you to release protected information without a release form, you should try to limit the information to what is necessary to get the job done.

**Rules for emergencies, investigations, and law enforcement requests**

A signed release is **not** required in some situations involving emergencies, investigations, and law enforcement requests. These exceptions are designed to allow quick and effective responses when health and safety are at risk.

* **Emergencies –** A signed release is not required in emergencies when:
  + An individual is injured or becomes suddenly ill and needs immediate medical attention.
  + An outbreak of a highly contagious disease has occurred.
  + An individual makes a serious threat to harm another specific person.
  + There is a risk to the health or safety of the individual or other persons.

In situations in which you would normally need to get a signed release, as soon as possible after the emergency situation ends, you must:

* + Try to obtain a signed release from the individual.
  + Provide a privacy notice to the individual.
* **Investigations into maltreatment of children or vulnerable adults** – Certain groups can inspect and copy health records without a signed release when investigating allegations of maltreatment (neglect or abuse) of a child or vulnerable adult. These groups include DHS, the county human services agency, local law enforcement, and other persons as authorized by law. In cases of alleged maltreatment of a child or vulnerable adult, the local human services agency and law enforcement agency can:
  + Review protected information concerning the child or vulnerable adult.
  + Interview the child **without parental consent**.
  + Interview other minors who currently live with or have lived with the alleged offender.
  + Conduct these interviews at any location that the local human service agency or law enforcement agency sees fit.

**Exception:** If the investigation requires the review of chemical health treatment records, a signed release or a court order is required.

* **Law enforcement requests** – In addition to maltreatment investigations, protected information can be shared with law enforcement without a signed release to investigate certain other alleged crimes or to catch offenders, such as:
  + During a criminal investigation of food stamp fraud.
  + When the law enforcement agency is seeking to arrest a fleeing felon, fugitive, or probation or parole violator.
  + When the information is necessary to protect the health or safety of individuals.

**Exceptions:**

* Unless a signed release is obtained, sharing chemical health treatment records with law enforcement generally requires a court order.
  + Releasing mental health data to law enforcement in pursuit of a fleeing felon requires a signed release or a court order.

**Important Note:** In some circumstances, mental health data may **not** be made available to the individual the data is about. For example, if a mental health professional determines that revealing the data to the individual client could harm the client, then the client may be restricted from accessing his own records. This restriction must have been placed on the record **before** the client made a request to see the record.

Sharing mental health data **without a signed release** is permitted only in the following circumstances:

* When an emergency situation arises.
* When the information is requested for the following types of investigations:
  + Public assistance fraud investigations.
  + Maltreatment investigations involving children or vulnerable adults.
* For purposes related to the provision of services to individuals when:
  + A health care provider refers an individual to a county for case management.
  + The appropriate county administrative or case management staff shares information to provide services.
  + Information is required to be shared with other members of the welfare system, such as community health boards, regional treatment centers, and state nursing homes.
  + Information is shared with the ombudsman for mental health and mental retardation.
  + Information is shared for the purpose of billing a county or state agency.

**Rule for releasing chemical treatment records**

There are a special federal statute and related rules that protect chemical health treatment records. They are given the highest level of protection. Sharing chemical health treatment records without a signed release or court order is permitted only in the following circumstances:

* For the purposes of sharing information within a program or with an agency that oversees the program.
* In a life-threatening medical emergency in which there is a threat to the physical health of the individual client.
* For an approved research project.
* For auditing how the program is being run and how program money is being spent.

In all of the following circumstances described below, a signed release or court order is required to release chemical health treatment records.

* **Maltreatment cases** – There are special rules for dealing with drug or alcohol treatment records in cases involving suspected maltreatment of children or vulnerable adults:
  + Drug or alcohol treatment records may be disclosed and used for purposes of *reporting suspected child abuse and neglect* to the appropriate authorities.
  + A court order is required to release additional records that may be requested during the course of a child maltreatment investigation or related court proceedings, and to release records used to report or investigate suspected abuse of vulnerable adults.
* **Law enforcement** – Sharing chemical health treatment records with law enforcement without a release requires a court order:
  + Even if an individual client is alleged to have committed a crime at the treatment center, the information that can be released is limited to the circumstances of the crime.
  + An individual's records cannot be released or used for criminal charges or investigations about that individual without a court order.
  + Even in the case of a fleeing felon, chemical health treatment records cannot be released without a court order.
* **Minors** – Special rules apply to children under 18 years of age. Generally, children can decide who can see their chemical health treatment records. Their parents are not automatically authorized to access those records.

***WHEN IN DOUBT – CHECK WITH YOUR HIPAA COMPLIANCE SPECIALIST OR YOUR SUPERVISOR!!!***

**IMPORTANT NOTE REGARDING PAPER DOCUMENTATION:**

*When using pen and paper for official documentation and you make an error, always draw a single line through the mistake, write “Error” and place your initials. NEVER USE WHITEOUT, COMPLETELY CROSS OUT, OR MAKE IT SO THAT AN ERROR CANNOT BE IDENTIFIED.*

*This is true for ALL official documentation that gets entered into the client’s file and could be reviewed by outside agencies (DHS, Health Insurance Companies, etc.) and/or subpoenaed.*

# Client Intakes & Case Closures

**Intakes**

In order for someone within the State of Minnesota to receive Adult Mental Health Targeted Case Management services, they must qualify as Serious and Persistently Mentally Ill (SPMI) with qualifying diagnostic assessment. Please see criteria on pages 1 and 2. Following is a brief overview of the Case Management Intake Process.

* A referral for case management is made to the local County Intake number.
* The Intake Worker takes the referral and obtains the most recent and available documents per agency policy (Hospital Intake Note and/or Discharge Summary, most recent Diagnostic Assessment).
* If a new Diagnostic Assessment needs to be completed, a county worker will have correspondence with the applicant directing on how to obtain the needed assessment
* If they qualify for Case Management services, the county assists to complete:
  + Releases of Information
  + Application for Social Services (per agency policy)
  + Medical Assistance Release
  + Some referrals, depending upon appropriateness
* Please follow any other intake procedures and policies of your agency.

**Case Closures/Transfer to CSP**

An important function of Case Management services is to know when to appropriately close a case management case. Ultimately as case managers we want to foster independence of our clients and not have them become dependent upon us.

**Case Closure**

According to Minnesota Statute 9520.0294, Case management services to an adult with SPMI shall terminate when one of the events listed below occurs:

* A mental health professional who has provided mental health services to the client furnishes a written opinion that the client no longer meets the eligibility criteria in Minnesota Statutes, section 245.4871, subdivision 6, for a child or 245.462, subdivision 20, for an adult. Upon receipt of the mental health professional's written opinion that the client no longer needs case management services, the client's case manager must inform the client of the client's ability to appeal the decision according to part 9520.0926.
* The adult and the case manager mutually decide that the adult, or in the case of a child, the case manager and the child's parent or legal representative or the child as described in part 9520.0907 and the case manager mutually decide that the client no longer needs case management services.
* The adult or, in the case of a child, the child's parent or legal representative or the child as described in part 9520.0907 refuses further case management services.
* Except for an adult in a residential treatment facility, regional treatment center, or acute care hospital for the treatment of a serious and persistent mental illness in a county outside the county of financial responsibility, no face-to-face contact has occurred between the case manager and the adult for 180 consecutive days because the adult has failed to keep an appointment or refused to meet with the case manager.

When a case manager is planning to close a case, the case must be reviewed with the Clinical Supervisor. If approved by the Clinical Supervisor, please follow agency policy to determine a need for ongoing case management through the county or if mental health provider should keep the case open. If the closure is approved by the county, the case manager sends a letter to the client notifying them of the closure and reasons. The process for re-referral and how to appeal the decision must be on the letter.

Potential Services to Refer Individuals

**ARMHS**

Adult rehabilitative mental health services (ARMHS) means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. The services also enable a recipient to retain stability and functioning if the recipient is at risk of losing significant functionality or being admitted to a more restrictive service setting without these services. In addition, the services instruct, assist, and support a recipient in areas such as medication education and monitoring, and basic social and living skills in mental illness symptom management, household management, employment-related, or transitioning to community living.

**Covered Services**

* The following seven services are billable as ARMHS:
* Basic living and social skills
* Certified peer specialist services
* Community intervention
* Functional assessment
* Individual treatment plan
* Medication education
* Transition to community living services

**Waivered Services**

**What are MA-Waiver programs?**

Minnesota's MA-Waiver programs provide additional services beyond those offered under [Medical Assistance](https://mn.db101.org/glossary_item.aspx?item-id=2010) (MA) or [Medical Assistance for Employed Persons with Disabilities](https://mn.db101.org/glossary_item.aspx?item-id=1955) (MA-EPD) to help people with disabilities live in their community rather than in an institution.

**How many different MA-Waiver programs are there?**

There are five different MA-Waiver programs in Minnesota, four of which serve people with disabilities who are under 65.

**What are the names of the MA-Waiver programs that serve people with disabilities?**

The MA-Waiver programs that serve people with disabilities are the:

* [Community Alternative Care (CAC) Waiver](https://mn.db101.org/glossary_item.aspx?item-id=2094)
* [Community Access for Disability Inclusion (CADI) Waiver](https://mn.db101.org/glossary_item.aspx?item-id=2095)
* [Developmental Disabilities (DD) Waiver](https://mn.db101.org/glossary_item.aspx?item-id=2096)
* [Brain Injury (BI) Waiver](https://mn.db101.org/glossary_item.aspx?item-id=2093)

**Do I have to be on Medical Assistance (MA) to qualify for a MA-Waiver program?**

Yes. You must be enrolled in some form of disability-based [MA](https://mn.db101.org/glossary_item.aspx?item-id=2010) to qualify for MA-Waiver services. This includes [Medical Assistance for Employed Persons with Disabilities](https://mn.db101.org/glossary_item.aspx?item-id=1955) (MA-EPD).

**Note:** Many people get income-based MA, not disability-based MA. If you get MA and are not sure whether it is based on your disability, [Chat with a Hub expert](javascript:void(0);) to check or contact your local [county human services agency](http://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/contact-us/county-tribal-offices.jsp).

**Does everyone on Medical Assistance (MA) qualify for a MA-Waiver program?**

No. You may only qualify for a MA-Waiver program if you have disability-based MA. Many people get income-based MA, not disability-based MA, and those people cannot apply for MA-Waiver programs. If you get MA and are not sure whether it is based on your disability, [Chat with a Hub expert](javascript:void(0);) to check or contact your local [county human services agency](http://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/contact-us/county-tribal-offices.jsp).

Even if you get disability-based MA, that does not mean you will qualify for a MA-Waiver program. There are specific eligibility criteria for each MA-Waiver program. Being on disability-based [Medical Assistance (MA)](https://mn.db101.org/mn/programs/health_coverage/ma/program.htm) or [Medical Assistance Employment for Persons with Disabilities (MA-EPD)](https://mn.db101.org/mn/programs/health_coverage/ma-epd/program.htm) is just one of those criteria.

**When should I apply for MA-Waiver services?**

If you’re interested in a particular MA-Waiver program, you should apply as soon as you think you meet the eligibility criteria. The number of people who can enroll in these programs varies from year to year and there may be a waiting list for the program you’re interested in.

**How do I apply for a MA-Waiver program?**

You can apply for any MA-Waiver program at your [county human service agency](https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/contact-us/county-tribal-offices.jsp).

If you are not already on some form of disability-based Medical Assistance (MA), you will need to apply for disability-based [MA](https://mn.db101.org/glossary_item.aspx?item-id=2010) (or [MA-EPD](https://mn.db101.org/glossary_item.aspx?item-id=1955)) in addition to the MA-Waiver program you're interested in.

While you’re at the county human services agency, you will need to schedule a [MnCHOICES](https://mn.db101.org/glossary_item.aspx?item-id=7162) assessment.

**Note:** You may only qualify for a MA-Waiver program if you have MA due to your disability. Many people get MA get it because they have low income, not because they have a [disability determination](https://mn.db101.org/glossary_item.aspx?item-id=846). If you get MA and are not sure whether you get it due to your disability, [Chat with a Hub expert](javascript:void(0);) to check or contact your local [county human services agency](http://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/contact-us/county-tribal-offices.jsp).

**Do I need a disability determination to qualify for a MA-Waiver program?**

Yes. You must be determined disabled by Social Security or the [State Medical Review Team (SMRT)](https://mn.db101.org/glossary_item.aspx?item-id=1965) to qualify for one of the four MA-Waiver programs that serve people with disabilities.

The one exception is the [Developmental Disabilities (DD) Waiver](https://mn.db101.org/glossary_item.aspx?item-id=2096). If you’re applying for the DD Waiver, you only need a documented diagnosis of developmental disability (determined during your [MnCHOICES](https://mn.db101.org/glossary_item.aspx?item-id=7162) assessment).

**What is a MnCHOICES assessment?**

A MnCHOICES assessment is a review of your situation to see what long-term care programs and services are best for you. A MnCHOICES assessment may include reviews of:

* Long-term care needs
* Personal care assistance options, and
* Developmental disability screening.

This can help you figure out what services and programs might help you live in the community, including [MA-Waiver programs](https://mn.db101.org/glossary_item.aspx?item-id=1969), [Medical Assistance](https://mn.db101.org/glossary_item.aspx?item-id=2010) (MA), [personal care assistance](https://mn.db101.org/glossary_item.aspx?item-id=979) (PCA) services, or other benefits. Even if you are not eligible for public benefits, the assessment can help you understand what services, accommodations, and resources exist.

All MA-Waiver applicants must go through a [MnCHOICES](https://mn.db101.org/glossary_item.aspx?item-id=7162) assessment before they can qualify for a MA-Waiver program.

**Note:** Long-Term Care Consultations (LTCCs) used to help people in a similar way. MnCHOICES assessments are replacing the LTCC throughout Minnesota.

**What is the Community Alternatives Care (CAC) Waiver?**

The Community Alternative Care (CAC) Waiver serves people with disabilities who need the level of care normally provided in a hospital. Services can range from home nursing services to extended nutritional therapies to modification of a home or car. Click [here](https://mn.db101.org/mn/programs/health_coverage/waivers/program2a.htm#cac) for a listing of services provided under the CAC Waiver.

**What is the Community Access for Disability Inclusion (CADI) Waiver?**

The Community Access for Disability Inclusion (CADI) Waiver provides services that help adults and children with disabilities live in the community rather than in a nursing facility. CADI Waiver services are wide-ranging and include services such as adult day care, homemaker services, independent living services, and home delivered meals. Click [here](https://mn.db101.org/mn/programs/health_coverage/waivers/program2b.htm#cadi) for a listing of services provided under the CADI Waiver.

**What is the Developmental Disabilities (DD) Waiver?**

The Developmental Disabilties (DD) Waiver helps people with developmental disabilities live in the community rather in an Intermediate care facility for persons with developmental disabilities (ICF/DD). To qualify for the DD Waiver, you must go through a [MnCHOICES](https://mn.db101.org/glossary_item.aspx?item-id=7162) assessment and be determined to have a developmental disability. Click [here](https://mn.db101.org/mn/programs/health_coverage/waivers/program2c.htm#dd) for a listing of services provided under the DD Waiver.

**What is the Brain Injury (BI) Waiver?**

The Brain Injury (BI) Waiver provides home and community based programs to people with a traumatic brain injury. BI Waiver enrollees must be able to function well enough to participate in their rehabilitation and they must require greater levels of service than can be attained through other Waiver programs. Click [here](https://mn.db101.org/mn/programs/health_coverage/waivers/program2d.htm#tbi) for a listing of services provided under the BI Waiver.

**Are there income and asset limits for MA-Waiver programs?**

There are no income or [asset limits](https://mn.db101.org/glossary_item.aspx?item-id=2064) for MA-Waiver programs, but you must stay eligible for disability-based Medical Assistance (MA) or Medical Assistance for Employed Persons with Disabilities (MA-EPD) to keep your waiver eligibility. *If you exceed the income or asset limits for MA or MA-EPD, you’ll lose your MA-Waiver services*.

**Community Support Programs (CSP)**

The community support services program must be designed to improve the ability of adults with serious and persistent mental illness to:

(1) find and maintain competitive employment;

(2) handle basic activities of daily living;

(3) participate in leisure time activities;

(4) set goals and plans; and

(5) obtain and maintain appropriate living arrangements.

The community support services program must also be designed to reduce the need for and use of more intensive, costly, or restrictive placements both in number of admissions and length of stay. Community support services are those services that are supportive in nature and not necessarily treatment oriented, and include:

(1) conducting outreach activities such as home visits, health and wellness checks, and problem solving;

(2) connecting people to resources to meet their basic needs;

(3) finding, securing, and supporting people in their housing;

(4) attaining and maintaining health insurance benefits;

(5) assisting with job applications, finding and maintaining employment, and securing a stable financial situation;

(6) fostering social support, including support groups, mentoring, peer support, and other efforts to prevent isolation and promote recovery; and

(7) educating about mental illness, treatment, and recovery.

**Intensive Residential Treatment Services (IRTS)**

Intensive residential treatment services (IRTS) are time-limited mental health services provided in a residential setting. Recipients of IRTS are in need of structure and assistance from 24-hour mental health staff and at risk of significant functional deterioration if they do not receive these services. IRTS are designed to develop and enhance the following:

* + Psychiatric stability
  + Personal and emotional adjustment
  + Self-sufficiency
  + Skills to live in a more independent setting

**Eligible Recipients**

* An eligible IRTS recipient must meet the following:
* Be 18 years old or older
* Be eligible for MA
* Meet the IRTS admission criteria

Individuals who are 17 years old and transitioning to adult mental health services may be considered for IRTS if the service is determined to best meet their needs. IRTS providers must secure a licensing variance in this situation.

Recipients may receive IRTS instead of hospitalization, if appropriate.

**IRTS Admission Criteria**

Admit a recipient to IRTS when a mental health professional determines the recipient meets the following:

* + Has a primary diagnosis of mental illness as determined by a [diagnostic assessment](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058048)
  + Has a completed [functional assessment](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_155980) using the domains specified in statute and have three or more areas of significant impairment in functioning
  + Has a completed [LOCUS](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_154047) assessment where a Level 5 is indicated
  + Is reasonably expected to commence or resume illness management and recovery skills or strategies at this level of service
  + Needs a 24-hour supervised, monitored and focused treatment approach to improve functioning and avoid relapse that would require a higher level of treatment
  + Is not responsive to an adequate trial of active treatment at a less intensive level of care
  + Is at risk of significant functional deterioration if IRTS are not received
  + Has one or more of the following:
  + History of two or more inpatient hospitalizations in the past year
  + Significant independent living instability
  + Homelessness
  + Frequent use of mental health and related services yielding poor outcomes in outpatient or community support treatment

**Crisis Services**

**Eligible Recipients**

To be eligible for MHCP adult crisis response services, a recipient must be:

* + Age 18 years or older
  + Experiencing a mental health crisis or emergency
  + Includes those recipients with a co-occurring substance abuse and mental health disorders who do not need the level of a detoxification facility.

**Covered Services**

* + Crisis Assessment
  + Crisis Intervention
  + Crisis Stabilization
  + Community Intervention
  + Certified Peer Specialists may provide Certified Peer Specialist services during all phases of the crisis response

**Crisis Assessment**

A crisis assessment is an immediate, face-to-face evaluation by a physician, mental health professional or crisis-trained mental health practitioner, to:

* + Identify any immediate need for emergency services
  + Determine that the recipient’s behavior is a serious deviation from his/her baseline level of functioning and caused by either a mental health crisis or emergency
  + Provide immediate intervention to relieve the recipient’s distress
  + Evaluate, in a culturally appropriate way and as time permits, the recipient’s current:
  + Life situation
  + Sources of stress
  + Symptoms
  + Risk behaviors
  + Mental health problems
  + Strengths and vulnerabilities
  + Cultural considerations
  + Support network
  + Level of Functioning
  + Whether the person will accept voluntary treatment
  + Whether the person has an advance directive
  + History and information obtained from family members

Conduct the crisis assessment in one of the following locations:

* + The recipient’s home
  + The home of a family member
  + Another community location

Determine the need for crisis intervention services, or referrals to other resources, based on the assessment.

**Crisis Intervention**

Mobile crisis interventions are face-to-face, short-term, intensive mental health services provided during a mental health crisis or emergency. These services help the recipient to:

* + Cope with immediate stressors and lessen his/her suffering
  + Identify and use available resources and recipient’s strengths
  + Avoid unnecessary hospitalization and loss of independent living
  + Develop action plans
  + Begin to return to his/her baseline level of functioning

Mobile crisis intervention services must be:

* + Available 24 hours per day, seven days per week, 365 days per year
  + Provided by a mobile team in a community setting
  + Provided promptly

**Crisis Intervention Treatment Plan**

With the recipient, develop, document and implement an initial crisis intervention treatment plan within 24 hours after the initial face-to-face intervention to reduce or eliminate the crisis. The treatment plan must be culturally and linquistically appropriate for the recipient.

* + List the recipient’s needs and problems identified in the crisis assessment
  + Identify:
  + Frequency and type of services to be provided
  + Measurable short-term goals
  + Specify objectives directed toward the achievement of each goal
  + Note cultural considerations
  + Recommend needed services, including crisis stabilization
  + Refer to appropriate local resources, such as:
  + County social services agency
  + Mental health services
  + Local law enforcement
  + Write clear progress notes of the outcome of goals
  + Identify frequency and type of services to be provided
  + Coordinate the planning of other services with the recipient’s case manager, if they have one

Update the crisis intervention treatment plan as needed to reflect changes in goals and services. If the recipient shows positive change in a baseline of functioning or a decrease in personal distress:

* + Make (and document) a referral to less intensive mental health services
  + Document short-term goals that have been met and when no further crisis intervention services are needed
  + If the recipient is unable to follow-up with a referral, the crisis response provider must link the recipient to the service and follow-up to ensure that the recipient is receiving the service.

A mental health professional and the recipient must approve and sign the treatment plan. If the recipient refuses to approve and sign the plan, note the refusal and the reason(s) for the refusal in the treatment plan. Give a copy of the treatment plan to the recipient.

If services continue 24 hours after the beginning of the face-to-face intervention:

* + A mental health professional must contact the recipient face-to-face, on the second day, to provide services and update the crisis treatment plan
  + The mental health professional is not required to be the same professional who was supervising the service when the face-to-face crisis intervention began

**Crisis Stabilization**

Crisis stabilization services are mental health services, provided after crisis intervention, to help the recipient return his/her functioning to the level it was before the crisis.

* + Provide stabilization services:
  + In the community
  + Based on the crisis assessment and intervention treatment plan
  + Consider the need for further assessment and referrals
  + Update the crisis stabilization treatment plan
  + Provide supportive counseling
  + Conduct skills training
  + Collaborate with other service providers in the community
  + Provide education to the recipient’s family and significant others regarding mental illness and how to support the recipient

**Crisis Stabilization Treatment Plan**

With the recipient, develop a crisis stabilization treatment plan within 24 hours of beginning services. The crisis stabilization treatment plan, at a minimum, must include:

* + Problems identified in the assessment
  + Measurable short-term goals and tasks to be achieved, including time frames for achievement
  + Specific objectives directed toward achieving each goal
  + Clear progress notes about outcomes of goals
  + List of recipient’s strengths and resources
  + Documentation of participants involved
  + A crisis response action plan, if another crisis should occur
  + Frequency and type of services initiated, including a list of providers, as applicable

A mental health professional and the recipient must approve and sign the treatment plan. If the recipient refuses to approve and sign the plan, note the refusal and the reason(s) for the refusal in the treatment plan. Give a copy of the plan to the recipient.

**Crisis Stabilization Provided in Residential Settings**

When Crisis Stabilization services are provided in any residential setting, the following requirements apply:

* + All staff must have immediate access to a qualified mental health professional or practitioner, 24-hours per day. The access can be direct or by telephone
  + A qualified mental health professional or practitioner must provide face-to-face contact with the recipient every day

When Crisis Stabilization services are provided in residential settings that serve four or fewer adults, the following additional requirements apply:

* + The setting must be licensed as an adult foster care home
  + If more than two individuals are receiving crisis response services, one of the following providers must be on site at least 8 hours per day:
  + Mental health professional
  + Crisis-trained mental health practitioner
  + Crisis-trained rehabilitation worker
  + Crisis-trained certified peer specialist

When Crisis Stabilization services are provided in residential settings that serve more than four adults, the following additional requirements apply:

* + The setting must be licensed under Rule 36 with a Crisis Stabilization variance
  + One of the following providers must be present 24 hours per day:
  + Mental health professional
  + Crisis-trained mental health practitioner
  + Crisis-trained rehabilitation worker

During the first 48 hours a recipient receives Crisis Stabilization services, at least two staff must be present 24 hours per day. Only one staff is required to be trained in providing crisis services

**Eligibility for Residential Crisis Stabilization Services**

In addition to the requirements listed under Eligible Recipients, recipients must:

* + Need residential crisis stabilization services to avoid hospitalization or loss of independent living
  + Be referred by a mental health crisis team, an Emergency Department physician or a mental health professional

**Authorization Requirements for Residential Crisis Stabilization**

Authorization is needed to exceed the maximum threshold of 10 days in a calendar month. To request authorization, submit an MHCP Authorization Form (DHS-4695) (PDF) with the following documentation:

* + Crisis Assessment, completed before intake by any of the following:
  + Crisis team
  + Mental health professional
  + Emergency department physician
  + Progress notes from the time of intake
  + Crisis Stabilization plan
  + Discharge plan or plans for transitioning to the community, including referrals to other service providers (services are coordinated after the recipient leaves the facility)
  + Identify symptoms that have not returned to the recipient’s baseline level
  + Other options considered, including hospitalization and community crisis stabilization
  + Written explanation of why the recipient needs more time and the anticipated outcome

Authorization is not required for crisis assessment, stabilization and intervention

**Community Intervention**

Community intervention may be provided as a crisis service when needed. When provided in the context of crisis response services, community intervention may be used to educate the recipient’s family and significant others on mental illness and ways to support the recipient.

**Medication Management**

Medication management determines the need for or the effectiveness of the medication prescribed for the treatment of a client’s symptoms of mental illness. Medication management for mental health is the prescription, administration, and review of medications and their side effects for the treatment of mental illness. It also involves the monitoring of prescription medications that a patient takes to verify that he/she is fulfilling the prescribed medication regimen. In addition, it is the responsibility of the physician or nurse to make certain that the patient is avoiding potentially unsafe drug issues. In general, medication management involves confirming that medication is taken correctly and in accordance with the appropriate dosage.

**Eligible Recipients**

Eligible recipients of Mental Health Medication Management must have a diagnosis of mental illness as determined by a diagnostic assessment.

**Covered Mental Health Medication Management Services**

Medication management is a service to determine a recipient’s need for a prescribed drug, or to evaluate the effectiveness of the prescribed drug as noted in the recipient’s written individual treatment plan (ITP).

Person-Centered Practices

Minnesota is moving toward person-centered practices in all areas of service delivery. As a state, Minnesota strives to make sure everyone who receives long-term services and supports and mental health services can live, learn, work and enjoy life in the most integrated setting. The goal is for people to lead lives that are meaningful to them. To do this, we must have a person-centered support system that helps people:

* Build or maintain relationships with their families and friends
* Live as independently as possible
* Engage in productive activities, such as employment
* Participate in community life.

Our support system must reflect that we understand, respect and honor the things each person thinks are important.

Person-centered practices are essential to this effort. Person-centered practices are flexible and adaptable. They encourage informed choice and creativity. We use person-centered practices because they increase people's quality of life.

Our transition to this person-centered approach reflects one of DHS’ core values: We focus on people, not programs. However, the person-centered approach is not unique to Minnesota. It is a practice that is emerging across a wide variety of fields that work with different people in different settings. Many state and federal policies now mandate person-centered delivery of long-term services and supports.

Funding Sources

**Grants (DHS)**

**AMHI**

<https://www.revisor.mn.gov/statutes/?id=245.4661>

Adult Mental Health Initiatives (AMHIs) were created under this model in 1996 in response to strong advocacy to strengthen investment in community mental health. The initiatives were designed to be flexible and responsive to local community needs. The AMHIs flexibility has been their greatest strength and vulnerability. AMHI is unique in its governance, membership, and resources and is responsive to local needs. The initial grants were funded through a transfer of state operated resources (dollars and staff members) in response to AMHI proposals and the amounts vary across the state.

**CSP**

See explanation of programming above.

<https://www.revisor.mn.gov/statutes/?id=245.4712>

**MA Case Management Billing**

Below are the Activity Codes used for entering billing information

**Table 1 Case Management Billing Codes**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Provider | Procedure | Modifier | Description | T&E  Units |
| CM | T2023 | HE | Targeted Case Management, Adult, face-to-face contact, has to be 1st contact. | 1 |
| CM |  |  | Non-billable contact with a professional. | 0 |
| CM | T2023 | HE U4 | Targeted Case Management, Adult, telephone contact, can only have 2 months in a row of telephone before you need another face-to-face. | 1 |
| CM |  |  | Non-billable client/non-client contact with other | 0 |
| CM |  |  | Case Management Travel (without client) | 1 unit per min |

## Examples of Billable Services for TCM and CSP (Productivity)

Below are some examples of billing scenarios to give some guidance on how to accurately and consistently document your Time and Effort.

1. You drive to a client’s home (8 minutes one way), conduct a home visit with a client and spend 35 minutes reviewing their ICSP goals and checking in with them. You then spend 20 minutes completing some county benefit paperwork. *This face-to-face client contact is documented using A TCM Progress Note for 1.25 hours. In the Progress Note you would document that 15 minutes was travel time, and 30 minutes was the CSP activity Benefits Assistance.*
2. You drive 20 minutes one way, pick up a client at their home and drive them to an appointment 30 minutes away. You did NOT accompany them into the appointment. You spend the drive checking in and working on rapport. *This face-to-face client contact is documented using A TCM Progress Note for 1.75 hours. You would note that .75 hours was travel time.*
3. You talk with a client on the phone for 20 minutes to check in, you do not expect to see this client this month. *This is coded as a Billable Face-to-Face documented using A TCM Phone Note with a time span of 15 minutes.*
4. You talk with a client’s guardian on the phone for 20 minutes. *This is documented using A TCM Phone Note with a time span of 15 minutes.*
5. You meet with a client’s guardian for 45 minutes regarding service needs of the client. *This is documented using A TCM note with a time span of 45 minutes.*
6. You meet with a client’s therapist for 15 minutes regarding progress. *This is documented using A TCM note with a 15-minute time span.*
7. You meet with a client’s parents for 2 hours who drop in to express concerns about their son/daughter. *This is a collateral contact and would be documented using A TCM note with a time span of 2 hours.*
8. You staff a client for 25 minutes in the Thursday Morning meeting. *This is clinical supervision and would be documented using A TCM Note with a time span of 30 minutes. This MUST BE SUBTRACTED the time you enter for the duration of the meeting. For example, if this meeting lasted 1 ½ hours, 1 hour would be the meeting and 30 minutes would be the staffing of your client.*
9. You staff a client individually with the clinical supervisor for 5 minutes. *This is clinical supervision and documented using A TCM Note with a time span of 15 minutes.*
10. You talk with a potential client about case management services for 15 minutes. *This is entered into your progress notes. See agency for more detail.*
11. You talk with a client on the telephone for 10 minutes at the beginning of the month. You discuss their ICSP goals, status of their housing and Medical Assistance applications and their job search. You schedule a time to meet with them in two weeks (within the same month). *This is entered as a Non-Billable Phone Contact and A TCM Phone Note is completed.*
12. You talk with a client on the telephone for 10 minutes at the beginning of the month. You discuss their ICSP goals, status of their housing and Medical Assistance applications and their job search. You do not schedule an appointment and do not expect to see them face-to-face that month. *This is entered as a Billable Phone Contact and A TCM Phone Note is completed. All other phone contacts with that client the remainder of the month would be “Non-Billable Phone Contacts”. If you do see the client face-to-face, it would be coded as Billable Face-to-Face, and let the Business Office know to change the first Phone Contact to a “Non-Billable Phone Contact”.*
13. You meet with a client at the office for 10 minutes. You discuss their ICSP goals, status of their housing application, status of their Medical Assistance application and their job search. *This is coded as a Billable Face-to-Face with a time span of 15 minutes.*
14. You leave a voicemail message for a client informing them their Social Security was approved. *This must be documented in using A TCM Note, but is not coded and no credit given for the time. Leaving a message for a client is never figured in productivity or Time and Effort*

Goodhue County

***Health and Human Services***

**Social Service Division**

426 West Avenue

Red Wing, MN 55066

(651) 385-3200 ●Fax (651) 267-4877

**Client Email / Texting Informed Consent Form**

Conditions for the use of email and texts

Staff cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Staff is not liable for improper disclosure of confidential information that is not caused by staff intentional misconduct. Clients/Parent’s/ Legal Guardians must acknowledge and consent to the following conditions:

1. Email and texting is not appropriate for urgent or emergency situations. Staff cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time. IF this is an emergency please call 911.
2. Email and texting should only be used for arranging appointment times or information. Anything related to mental health should be talked about over the phone or in person.
3. Email and texting will usually be documented into the client’s file.
4. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information. Staff is not liable for breaches of confidentiality caused by the client or any third party.

Risk of using email and texts

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

1. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
4. Employers and on-line services have a right to inspect emails sent through their company systems.
5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
6. Emails and texts can be used as evidence in court
7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that my staff may impose to communicate with me by email or text.

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Workgroup # \_\_\_\_\_\_\_\_\_\_\_\_

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_