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IN THE MATTER OF THE PROPOSED
DEPARTMENT OF HUMAN SERVICES
RULES ESTABLISHING STANDARDS
AND PROCEDURES RELATED TO CASE
MANAGEMENT SERVICES TO CHILDREN
WITH SEVERE EMOTIONAL DISTURBANCE AND
ADULTS WITH SERIOUS AND PERSISTENT
MENTAL ILLNESS MINNESOTA RULES,
PARTS 9520.0900 TO 9520.0926

STATEMENT OF NEED
AND REASONABLENESS

INTRODUCTION

Minnesota Rules, parts 9520.0900 to 9520.0926, are proposed by the Department of Human Services to establish program standards and procedures for case management services. Counties provide case management services, directly or under contract, to children with severe emotional disturbance and to adults with serious and persistent mental illness.

Case management services for children with severe emotional disturbance and for adults with serious and persistent mental illness are designed to assist eligible persons in gaining access to needed medical, social, educational, and other services that will help them to remain and function in the community. One goal of case management services is to ensure that children with severe emotional disturbance and adults with serious and persistent mental illness receive necessary services and that the services are coordinated by a case manager responsible for monitoring the person's progress on a continuing basis. Case management services should result in improved service delivery, non-duplication of services, and early intervention when a child's emotional status or an adult's mental health appears to be deteriorating.

Minnesota Statutes, section 245.4711, subdivision 9, directs the Commissioner to revise permanent rules governing case management services for adults with serious and persistent mental illness to improve rule flexibility, establish a comprehensive service coordination, require case managers to arrange for standardized assessments of side effects of psychotropic medication, establish a reasonable caseload limit, provide reimbursement for transportation costs of case managers, and review the eligibility criteria for case management services covered by medical assistance. Although subdivision 9 required the rule revision to be completed by July 1, 1992, the Department adopted the required rule revisions as emergency amendments to parts 9505.0476 to 9505.0491, which became effective December 27, 1991.

Minnesota Statutes, section 245.484 directed the Commissioner to adopt rules as necessary to carry out Minnesota Statutes, section 245.461 to 245.486 and 245.487 to 245.4888. Additionally, Minnesota Statutes, section 245.484 as amended in 1991 directed the Commissioner to adopt rules to govern implementation of case management services for eligible children in Minnesota Statutes, section 245.4881. Emergency rules for case management services to children became effective December 27, 1991, simultaneously with the emergency amendments to the existing rules related to case management services for persons with serious and persistent mental illness.

Minnesota Statutes, section 245.484 requires the Department to adopt permanent rules related to case management services for eligible children by January 1, 1993. The proposed rules, parts 9520.0900 to 9520.0926, when adopted, will

replace both the emergency rules related to case management services to children with severe emotional disturbance, parts 9520.0900 to 9520.0926 [Emergency] and the permanent rules and their emergency amendments related to case management services for persons with serious and persistent mental illness and to persons with servere emotional disturbance, parts 9505.0476 to 9505.0491.

In developing permanent rules related to case management services, the Department thoroughly reviewed current parts 9505.0476 to 9505.0491 and their emergency amendments, (Rule 74), and parts 9520.0900 to 9520.0926 [Emergency]. One purpose of the review was to determine how to respond to comments made during the three and one half years Rule 74 has been in effect. During that time, many persons have commented that the combination of program standards for case management services and medical assistance provider standards for service to medical assistance recipients set forth in Rule 74 is confusing. For example, counties question whether all of the Rule 74 requirements apply to all persons who are eligible for case management services or only to medical assistance recipients who are eligible for case management services. Another purpose was to determine whether Rule 74 departs from the Department's customary approach to placing program standards in one rule and medical assistance provider standards and payment rates in another rule. A third purpose was to identify clearly the case management services that are eligible for medical assistance payment and those case management services that are part of the model being adopted by the State but that may not be eligible for medical assistance payment or may be eligible for medical assistance payment subject to certain limitations. A fourth purpose was to remove the confusion about the standards applicable to children's case management. Under emergency Rule 79 and amended Rule 74, children with severe emotional disturbance may receive case management services under either amended Rule 74 or emergency Rule 79. County case managers and eligible clients were confused about the difference between these rules and about the basis for choosing the one appropriate to the child's needs. Additionally it should be noted that Rule 74 sets standards for case management services to both children and adults whereas Rule 79 sets standards for children's case management services only. For these reasons, the Department is proposing parts 9520.0900 to 9520 as the rule which sets standards related to case management services for children with severe emotional disturbance and their families and for adults with serious and persistent mental illness. At the same time, the Department is proposing part 9505.0322, a medical assistance rule which sets medical assistance standards to receive payment as a provider of case management services to medical assistance recipients. Proposed part 9505.0322 sets forth the payment limitations. Additionally, present part 9505.0491, subparts 7 and 8, permanent rules which specify the medical assistance payment rate for case management services, will be retained but the remainder of Rule 74 and its emergency amendments will be repealed as of the effective date of parts 9520.0900 to 9520.0926 and 9505.0322. (Proposed parts 9520.0900 to 9520.0926 and 9505.0322 are proceeding sinultaneously through the controversial rule adoption procedure set forth in the Administrative Procedure Act.) Program standards for social services, including mental health and case management services, have customarily been established in one rule for children and another rule for adults. Proposed parts 9520.0900 to 9520.0926 deviate from this pattern by setting forth the standards for case management

services for both children and adults. Minnesota Statutes, section 245.487, subdivision 3, clause (8) requires the commissioner to "create and ensure a unified, accountable comprehensive children's mental health system" that "assures a smooth transition from mental health services appropriate for a child to mental health services needed by a person who is at least 18 years old." Likewise, Minnesota Statutes, section 245.4874, clause (11) requires the county board in each county to "assure that children's mental health services are coordinated with adult mental health services...so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age." Compliance with these requirements is assisted when the standards for the services are coordinated and presented in a manner that assures consistency of approach in providing the same type of mental health service needed by children and adults. Therefore, proposed parts 9520.0900 to 9520.0926 set forth standards for case management services to children with severe emotional disturbance and to adults with serious and persistent mental illness. Readers should note that where standards for children are different from those for adults the standards for children are in a separate part, subpart, or item which precedes the corresponding standards for services to adults.

The Department is also proposing amendments to part 9505.0323, Mental Health Services under Medical Assistance, that are necessary to assure consistency with proposed parts 9520.0900 to 9520.0926 and 9505.0322 and the Minnesota comprehensive mental health act.

Rule Development Procedures

In developing the proposed rule, the Department followed the procedures mandated by the Administrative Procedure Act and the Department to solicit opinion and guidance from persons who will be affected by the rules when adopted. Notices to Solicit Outside Information or Opinions about Case Management Services for Children with Severe Emotional Disturbance were published in the State Register on December 2, 1991 (16 S.R. 1411) and January 13, 1992 (16 S.R. 1688.) The Notice to Solicit Outside Information or Opinions about Case Management Services to Persons with Serious and Persistent Mental Illness was published in the State Register on December 30, 1991 (16 S.R. 1594.) Finally, the Notice to Solicit Outside Information or Opinions about Eligibility to Receive Medical Assistance Payment for Mental Health Case Management Services was published in the State Register on February 10, 1992 (16 S.R. 1886.)

The Department convened a rule advisory committee comprised of county representatives, advocates, members of the state mental health advisory council and children's subcommittee, and providers. See Attachment 1. The committee met four times between December, 1991 and March 31, 1992, for a total of 14 hours. A task force of advisory committee members chosen by the committee to represent the committee as a whole for the purpose of developing rule provisions related to service outcomes met for an additional three hours. All comments on the proposed rule, including written comments received from committee and non-committee members, were reviewed and considered by the Department as the proposed rule was drafted.

Compliance with mandates reform legislation

Parts 9520.0900 to 9520.0926 are the first permanent social service rules proposed by the Department since the enactment of the mandates reform

legislation applicable to community social services, including mental health services, under Minnesota Statutes, section 256E.081 and the issuance of Governor Carlson's Executive Order 91-12 to simplify and eliminate prescriptive rule requirements. In preparing rules that attempt to meet these requirements of simplification and decreased procedural prescriptiveness, the Department placed the rule's focus on service outcomes rather than procedures insofar as possible. At the same time, the Department has been cognizant that the Administrative Procedure Act prohibits rule provisions that delegate unbridled discretion, that lack a reasonably clear policy or standard of direction, or that lack the specificity necessary to avoid vagueness. Thus, the Department has attempted to strike a balance between over prescriptiveness and too much simplification and to provide reasonable flexibility for county implementation of the rule in a manner consistent with a county's circumstances.

To assist the Department in focusing on outcomes, the Department contracted with Dr. Michael Q. Patton, a nationally recognized expert in the field of evaluation methodology and research. (See Attachment 2 for Dr. Patton's resume.) Dr. Patton worked with Department staff, the advisory committee as a whole, and the advisory committee's task force to develop outcomes appropriate to the services to be provided to eligible persons according to this rule. See parts 9520.0904 and 9520.0905 and their SNRs which set forth outcomes for case management services to children with severe emotional disturbance and to adults with serious and persistent mental illness. The Department will present Dr. Patton as an expert witness to testify on behalf of the Department. See pagexxx for a brief statement of his testimony.

Small Business Consideration

In preparing these rules, the Department considered the requirements of Minnesota Statutes, section 14.115 about small business considerations in rulemaking but determined that these rules are exempt from these requirements under Minnesota Statutes, section 14.115, subdivision 7(2) and (3).

9520.0900 SCOPE AND AVAILABILITY

Subpart 1. Scope. This subpart states the purpose and scope of the proposed rule and lists the state laws that authorize the Department to adopt this rule and that govern the content of the rule. This subpart is necessary and reasonable because it informs affected persons of the applicable laws and the reason for the rule, thereby assisting affected persons in understanding the statutory basis for the rule. Minnesota Statutes, sections 245.487 to 245.4888 comprise the Minnesota comprehensive children's mental health act and sections 245.461 to 245.486 comprise the Minnesota comprehensive adults' mental health act. Minnesota Statutes, section 256E.09 governs the development and contents of county community social service plans, of which mental health services are a required component. See also the definition of community social services in Minnesota Statutes, section 256E.03, subdivision 2(a). Minnesota Statutes, chapter 256G (the Minnesota unitary residence and financial responsibility act) governs the Minnesota human services system and applies to establishing financial responsibility for programs administered by the commissioner of human services, including the components of community social services.

Subpart 2. Availability. This subpart is necessary because it clarifies to whom case management services are available and the possible sources of funding to pay for the services. This subpart is consistent with Minnesota Statutes, section 245.4881, which requires county boards to make case management services available to children with severe emotional disturbance and their families who are residents of the county and who request or consent to the services. This subpart also is consistent with Minnesota Statutes, section 245.4711 in regard to the availability of case management services to adults with serious and persistent mental illness. Additionally this subpart is consistent with Minnesota Statutes, sections 245.486 and 256E.081 in regard to the availability and use of funds by the counties. These funds include grants to counties for adult case management and children's case management; grants for community social services under Minnesota Statutes, section 256E.06 and title XX allocations under Minnesota Statutes, section 256E.07; grants for case management services under Minnesota Statutes, section 256E.12, and all other commonly available state and federal funding sources.
Minnesota Statutes, section 245.4881, subdivision 1, paragraph (b) for services to children and section 245.4711, subdivision 1, paragraph (b) for services to adults specify that medical assistance must be billed if case management services are provided to medical assistance eligible clients. Including in this subpart information about required billings for medical assistance eligible clients is necessary and reasonable because it informs affected persons and thereby encourages compliance with the statute.

Parts 9520.0900 to 9520.0926 establish a uniform program standard for case management services to children with severe emotional disturbance and adults with serious and persistent mental illness without regard to the client's eligibility for medical assistance or other funding sources. A single standard is reasonable because a single standard assures equitable treatment when the service needs are the same. It would be unreasonable to have standards based on the funding source because the result would be a multi-tiered availability of treatment for the same conditions. Further, a uniform standard is reasonable because it facilitates program administration by the county. The county can implement and monitor the program without regard for the source of the funding.

9520.0902 DEFINITIONS

Subpart 1. Scope. This subpart states that the terms defined have meanings specific to parts 9520.0900 to 9520.0926. This part and the definitions that follow in parts 2 to 42, are necessary to inform persons affected by the rule, to provide consistent terminology throughout the rule, and to clarify terms used in this rule.

Subpart 2. Adult. This subpart is reasonable because it is the same as the definition of "adult" in Minnesota Statutes, section 645.45, clause (3).

Subp. 3. Case Manager. This definition is reasonable because it is consistent with Minnesota Statutes, sections 245.462, subdivision 4 and 245.4871 subdivision 4.

Subp. 4. Case management provider. This definition is reasonable because it

is consistent with Minnesota Statutes, sections 245.462, subdivision 4 and 245.4871, subdivision 4 which provide that a case manager is to be employed by the county or other entity authorized by the county board to provide case management services.

Subp. 5. Case management services. Minnesota Statutes, section 245.4871, subdivision 3, in the case of children, and section 245.462, subdivision 3, in the case of adults, define the term case management services. Consistency with statutes is reasonable because it complies with the law. Including within the definition a reference to the part which specifies the desired outcomes of case management services to children and to the part which specified the desired outcomes of case management services to adults is reasonable because the reference informs affected persons.

Subp. 6. Case management team. This term describes a model of case management services that is the service model recommended by the Child Adolescent Services System Program (CASSP) of the Technical Assistance Center of Georgetown University and the Florida Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children at the Florida Mental Health Institute. This model emphasizes the involvement of the parent, child, and persons from other agencies who provide services other than the child's case management services. The definition is reasonable as it is consistent with a nationally accepted community standard of practice that assists the coordination of the child's services. It is reasonable to limit the participation of other persons or service providers to those requested by the child's parent or legal representative as the child's parent or legal representative is the person with the legal authority to make decisions for the child.
Minnesota Statutes, section 245.4711, in subdivision 3 specifies that a case manager is responsible for developing an adult's individual community support plan and in subdivision 4 specifies, "[t]o 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...community support plan." The model of case management services for an adult differs from the model for children as the adult's family members and advocates are not members of the case management team. An adult has a right to privacy about matters affecting the adult. Furthermore, unless determined otherwise by a court, an adult is responsible to make decisions about his or her own needs. The involvement of members of the adult's family and other persons significant to the adult must be authorized by the adult. See part 9520.0905, item B. Thus, defining the adult's case management team as the adult, adult's case manager and representatives of the agencies under county contract for case management services to the adult is reasonable because it is consistent with Minnesota Statutes, section 245.4711, subdivision 4 and the adult's right to privacy and to decide whether other persons will be involved in developing and implementing the adult's services.

Subp. 7. Child. The definition is consistent with Minnesota Statutes, section 245.4871, subdivision 5.

Subp. 8. Child with severe emotional disturbance. This subpart describes the

condition of child who is eligible for case management services. Defining the term by citing the statute establishing the definition is reasonable because it enusres consistency with the statute set forth in the Comprehensive children's mental health act.

Subp. 9. Client. This subpart is necessary to clarify a term used in these rules. It is an abbreviation used to include children with severe emotional disturbance and adults with serious and persistent mental illness who are eligible to receive case management services under this rule. It is reasonable to use this term because it shortens the rules.

Subp. 10. Clinical supervision. The definition of clinical supervision is reasonable as it is consistent with Minnesota Statutes, section 245.4871, subdivision 7, in the case of a child and with Minnesota Statutes, section 245.462, subdivision 25 in the case of an adult. The definition requires a mental health professional to carry out the oversight responsibility for individual treatment plans and individual mental health service delivery including that provided by the case manager.

Subp. 11. Commissioner. The definition of "commissioner" is reasonable because it is consistent with Minnesota Statutes, sections 245.4871, subdivision 8 and 245.462, subdivision 5. The definition also is consistent with Minnesota Statutes, section 15.06, subdivision 6, which authorizes the commissioner to delegate to any subordinate employee specific statutory powers and authority.

Subp. 12. Community support services program. Using the statutory definition of "community support services program" is reasonable to insure consistency with statute. Day treatment services are added to the definition for purposes of this rule because day treatment services are community-based services that are available to assist a client to function and remain in the community. (See subpart 14.) Thus, day treatment services serve the same purpose as other services listed in Minnesota Statutes, section 245.462, subdivision 6, which are "....designed to help adults with serious and persistent mental illness to function and remain in the community." Including day treatment services within the definition of community support services also is consistent with the statutory definition of family community support services. See Minnesota Statutes, section 245.4871, subdivision 17. See also subpart 20 which defines "family community support services " and its SNR.

Subp. 13. County board. The definition of county board is reasonable because it is consistent with Minnesota Statutes, section 245.4871, subdivision 9 and section 245.462, subdivision 7..

Subp. 14. County of financial responsibility. The definition of county of financial responsibility is reasonable because it refers to the statute which applies to those programs administered by the commissioner for which residence is a determining factor in establishing financial responsibility. See Minnesota Statutes, section 256G.02, subdivision 4.

Subp. 15. Day treatment services or day treatment program. This subpart is

necessary to describe the structured program of treatment and care provided to a child or an adult. (See subparts 12 and 20 their SNRs.) Day treatment is a family community support service available to children with severe emotional disturbance or a community support service available to adults with serious and persistent mental illness. This provision is reasonable because it is consistent with Minnesota Statutes, section 245.4871, subdivision 10 and Minnesota Statutes, section 245.462, subdivision 8.

Subp. 16. Diagnostic assessment. Defining the term "diagnostic assessment" by citing the statutes in which it is defined is reasonable as it ensures consistency with the statutes.

Subp. 17. Emergency services. Emergency services are among the services available to a case management client. The definition is reasonable because it is consistent with Minnesota Statutes, sections 245.4871, subdivision 11 and 245.462, subdivision 9.

Subp. 18. Emotional disturbance. It is reasonable to define the term "emotional disturbance" by reference to the statute defining the term as it ensures consistency with the statute, Minnesota Statutes, section 245.4871, subdivision 15.

Subp. 19. Family. Relying on Minnesota Statutes, section 245.4871, subdivision 16 to define "family" is reasonable because it ensures consistency with the Minnesota comprehensive children's mental health act. Adding the reference to statutes related to Indian family preservation in the case of Indian children is reasonable as it ensures consistency with the applicable statutes. See Minnesota Indian family preservation act, Minnesota Statutes, section 257.35 to 257.3579.

Subp. 20. Family community support services. This term is necessary to describe the network of services available to children eligible for case management services. The definition is reasonable because it is consistent with Minnesota Statutes, section 245.4871, subdivision 17.

Subp. 21. Functional assessment. A functional assessment is among the services provided to a client by the client's case manager. Defining the term by citing the statutes containing the definition is reasonable as it ensures consistency with the statutes.

Subp. 22. Individual community support plan. The individual community support plan identifies the services needed by an adult with serious and persistent mental illness. Defining the term by citing the statute containing the definition is reasonable as it ensures consistency with the statute.

Subp. 23. Individual family community support plan. The individual family community support plan identifies the services needed by a child with severe emotional disturbance and the child's family. Defining the term by citing the statute containing the definition is reasonable as it ensures consistency with the statute.

Subp. 24. Individual treatment plan. "Individual treatment plan" is a term

used in these rules in relation to treatment services for children and adults. Defining the term by citing the statutes containing the definition is reasonable as it ensures consistency with the statutes which differentiate the treatment plan from a child's individual family community support plan and an adult's individual community support plan. An individual family community support plan (IFSCP) or individual community support plan (ICSP) is an umbrella plan that identifies all of the services the client needs to treat the client's mental or emotional condition, develop independence, or improve the client's functioning in the community. The number of services identified in an IFCSP or ICSP will depend on how many services the client needs. The identified services include mental health services such as psychotherapy and other services such as housing and vocational services. Additionally in the case of child, the IFCSP will include services needed by the child's family because of the child's severe emotional disturbance. Each one of the mental health services identified in the client's ICSP or IFCSP will in turn be provided according to an individual treatment plan developed by the mental health service provider. A treatment plan contains the goals, objectives and treatment strategy for a specific mental health service. Thus a client may have more than one individual treatment plan depending on the number of mental health services needed by the client, but the client will have only one IFCSP or ICSP.

Subp. 25. Inpatient hospital. Defining the term "inpatient hospital" by citing the statute containing the definition for "hospital" under the Minnesota health care cost information act is reasonable as it ensures consistency with part 9505.0175, subpart 16, which applies to medical assistance providers.

Subp. 26. Legal representative. Minnesota Statutes, section 525.619 sets forth the powers and duties of child's guardian appointed by a court. Minnesota Statutes, 525.619 (c) empowers a guardian appointed by the court "to authorize medical or other professional care, treatment or advice" and specifies the limitations applicable to the guardian's authority. Minnesota Statutes, section 257.351, subdivision 8, a provision of the Indian family preservation act, specifies who may act on behalf of an Indian child if the parent's rights have been voluntarily transferred or terminated under state law. This term is an abbreviation for such persons who are authorized to decide on services for a child with severe emotional disturbance. Use of an abbreviation is reasonable as it shortens the rule. Defining the abbreviation by citing the statutes is reasonable because it ensures consistency with the statutes.

Subp. 27. Local agency. This is the agency which administers the medical assistance program and case management services provided by a county board on a day to day basis under the supervision of the Department of Human Services. The term is used in this rule and is defined solely for identification purposes.

Subp. 28. Mental health practitioner. Persons who meet at least the qualifications of a mental health practitioner are qualified to be case managers. Defining the term "mental health practitioner" by citing the statute containing the definition is reasonable as it ensures consistency with

the statute.

Subp. 29. Mental health professional. This term is used in these rules to describe the qualifications of the professional who supervises case managers and who may provide certain mental health services to case management clients. Defining the term by citing the statutes containing the definition is reasonable as it ensures consistency with the statutes. Additionally, part 9505.0323, subpart 31 sets forth the circumstances under which certain mental health practitioners may receive medical assistance payment for mental health services which fall within the scope of practice of mental health professionals. Referencing the requirements of part 9505.0323, subpart 31 is reasonable as it ensures consistency with another department rule related to mental health services that affects the payment for case management and other mental health services governed by parts 9520.0900 to 9520.0926.

Subp. 30. Mental health services. This term is used in this rule to describe mental health services available to children with emotional disturbance and adults with mental illness. This group of persons includes clients who receive case management services under these rules. Defining the term by citing the statutes containing the definition is reasonable as it ensures consistency with the statutes.

Subp. 31. Mental illness. As used in this rule, the term "mental illness" indicates the full range of diagnostic codes applicable to mental illness including those under which adults with serious and persistent mental illness are found. Defining the term by citing the statute containing the definition is reasonable as it ensures consistency with the statute.

Subp. 32. Minority race or minority ethnic heritage. Part 9560.0020, subpart 9a defines "minority race or minority ethnic heritage" within the context of the Minnesota adoption program and the social services supportive of the adopted child's integration into the new family. The adoption program is implemented by a local social service agency, which is a county agency, or a child placing agency licensed by the commissioner. Because case management services are part of a county's social service program, it is reasonable to use the definition applicable to another social service program and thereby assure consistency and avoid confusion. The Department notes that, although Minnesota Statutes, sections 259.255 and 259.455 both refer to consideration of a child's minority racial or minority ethnic heritage when placing a child for adoption or attempting to recruit an adoptive family, they do not define the term. It is reasonable to refer to the definition in the rules setting forth standards for the Minnesota adoption program pursuant to the authorization in Minnesota Statutes, section 245A.09, section 259.40, subdivision 10; and section 259.45, subdivision 9 as a definition which is a part of the rules is an authorized legal standard.

Subp. 33. Outpatient services. This term is a type of mental health service that may be necessary for a client. The service is one that must be provided by a county as specified in the mental health component of its social services plan. Defining the term by citing the statutes containing the definition is reasonable as it ensures consistency with the statutes.

Subp. 34. Parent. The definition clarifies who is a parent for purposes of this rule. It is reasonable because it provides an abbreviation for "birth or adoptive mother or father" and this shortens the rule. Consent to services for a child and to release of information about the child is a right and responsibility of the child's parent or parents. Parts 9520.0900 to 9520.0926 require such consent in order for the child to receive case management or other mental health services and for the release of information about the child to the child's other service providers. See part 9520.0907. Termination of the parents' rights also ends the parents' right to give or withhold consent for the child's services and the release of information about the child. The decision to terminate parental rights can only be made by a court. Therefore, it is reasonable to exclude from the definition a person whose parental rights in relation to the child have been terminated by a court as such a person no longer has the right or the responsibility to make decisions on behalf of the child.

Subp. 35. Professional home-based family treatment. Professional home-based family treatment is a type of mental health service available to children with emotional disturbance. Defining the term by citing the statute containing the definition is reasonable as it ensures consistency with the statutes.

Subp. 36. Residential treatment. Residential treatment is a type of mental health service available to children with severe emotional disturbance and to adults with serious and persistent mental illness. Defining the term by citing the statutes establishing the definition is reasonable as it ensures consistency with the statutes.

Subp. 37. Screening. "Screening" is a term applied in these rules to the process of determining if the proposed inpatient or residential treatment is necessary, and appropriate to a child's individual treatment needs. Defining the term by citing the statute establishing the definition is reasonable as it ensures consistency with the statute.

Subp. 38. Serious and persistent mental illness. This definition describes the condition of an adult who is eligible to receive case management services under these rules. Defining the term by citing the statute establishing the definition is reasonable as it ensures consistency with the statute.

Subp. 39. Service provider. This term is used in these rules to indicate the individual or agency that provides mental health services including case management services. Defining the term by citing the statutes establishing the definition is reasonable as it ensures consistency with the statute.

Subp. 40. Special mental health consultant. A special mental health consultant is a term used in these rules to describe a person who has special expertise in providing health services to a child of minority race or minority ethnic heritage. Defining the term by citing the statute establishing the definition is reasonable as it ensures consistency with the statute.

Subp. 41. Team Coordinator. Under these rules, a child's parent, or, if appropriate, the child, may request that a person other than the case manager serve as the case management team coordinator. Part 9520.0916, subpart 2

specifies the responsibilities and activities of a team coordinator. Defining the term by citing the rule part specifying the team coordinator's responsibilities and activities is reasonable as it sets a standard and avoids confusion and misunderstanding among members of the case management team.

Subp. 42. Therapeutic support of foster care. This term applies to a family community support service that provides a clinical support system to foster parents of a child with severe emotional disturbance. Defining the term by citing the statute establishing the definition is reasonable as it ensures consistency with the statute.

Subp. 43. Updating. "Updating" is a term used in these rules to describe the process of reviewing and revising a client's diagnostic assessment. See parts 9520.0908 and 9520.0909. Defining the term by citing the statutes establishing the definition is reasonable as it ensures consistency with the statutes.

9520.0903 COUNTY BOARD RESPONSIBILITIES

Subpart 1. **Responsibilities for case management services.** This subpart states the general responsibility of county boards to make case management services available for children with severe emotional disturbance and adults with serious and persistent mental illness. See Minnesota Statutes, sections 245.4874, clause (8); 245.4875, subdivision 2, clause (10); and 245.4881, subdivision 1 which state the county's obligation to children with severe emotional disturbance. Also see Minnesota Statutes, sections 245.465, subdivision 1, clause (3); 245.466, subdivision 2, clause (9); and 245.4711, subdivision 1 which state the county's obligation to adults with serious and persistent mental illness. This subpart is necessary and reasonable because it informs the affected agency, the county board, of its statutory obligations and thereby encourages compliance.

Items A and B. These items are consistent with Minnesota Statutes, sections 245.467, clause (7); 245.4711, subdivision 5; 245.4874, clause (5); and 245.4876, subdivision 1, clauses (7) and (9).

Item C. This item is consistent with Minnesota Statutes, sections 245.4874, clause (13) and 245.4876, subdivision 1, clause (2).

Item D. This item is consistent with Minnesota Statutes, sections 245.484 and 256E.081, subdivisions 2 to 4.

Item E. This item is consistent with Minnesota Statutes, section 245.4711, subdivision 9, clause (4) which requires "rules to establish a reasonable case load limit for case managers." It also is consistent with Minnesota Statutes, section 245.4711, subdivision 1, paragraph (a) and 245.4881, subdivision 1, paragraph (a) which require a county's case management staffing ratios to be sufficient to serve the needs of the client. See subpart 2 and its SNR.

Item F. This item is reasonable as it informs county boards of their oversight responsibility for assuring the required meetings and procedures related to case management services take place. Minnesota Statutes, section 245.4874, clause (3) in regard to children, and section 245.462, subdivision 1, clause (2) in regard to adults requires the county board to develop biennial mental health components of the community social services plan which

considers the report of the local mental health advisory council about unmet needs. For requirements placed on the county about establishing and considering the advice of the local children's and adult mental health councils, see Minnesota Statutes, section 245.4875, subdivision 1 in regard to children and section 245.466, subdivision 5 in regard to adults. This item applies not only to the meetings necessary for these councils to carry out their responsibilities of reviewing, evaluating, and recommending regarding the local mental health system including case management services but also to meetings between the case manager and the client. For example, see parts 9520.0908 about contact between person designated by the county board and the child and child's parent or the adult; part 9520.0914, subpart 2 item A (5) and item B (5); part 9520.0916, subpart 1; part 9520.0917.

Subp. 2. **Limit on size of case manager's caseload.** This subpart is necessary to comply with the requirement of Minnesota Statutes, section 245.4711 subdivision 9, clause (4) that the Department establish in rule a "reasonable caseload limit" for case managers of adults with serious and persistent mental illness. Similar language is not found in the Minnesota comprehensive children's mental health act, Minnesota Statutes, sections 245.4871 to 245.4888. However, the Minnesota comprehensive children's mental health act does require county boards to provide case management staffing ratios that are "sufficient to serve the needs" of children who have severe emotional disturbance. See Minnesota Statutes, section 245.4881, subdivision 1. It would be unreasonable to establish an average caseload limit for adults with serious and persistent mental illness but fail to establish one for children with severe emotional disturbance because both adults and children have similar needs for case management services. These services provide access to and coordination and monitoring of mental health and other services needed by the clients to remain and function in the community. An average caseload limit for case managers is necessary to enable the case managers to carry out effectively their responsibilities under the law and complies with the intent of the Minnesota comprehensive children's mental health act.

The Department initiated the development of rule provisions on the caseload size limit for the emergency amendments to Rule 74 in 1991 in discussions with the advisory committee on the emergency rule. The discussion included a review of the July 1988 fiscal note for the original Rule 74 which assumed that full compliance with the original Rule 74 would require reduction of average caseload sizes to 30:1 and that new medical assistance payments (as approved and budgeted by the 1987 Legislature) would allow hiring of the additional case managers needed to reduce caseload sizes to 30:1. An initial emergency rule draft of a caseload size limit reviewed by the advisory committee contained the average caseload limit of 30 clients to one full-time equivalent case manager. Members of the advisory committee reported that many counties had not yet achieved the 30:1 ratio. Some members of the advisory committee reported that, in their experience, a ratio of 30:1 is a reasonable professional standard that counties should strive to attain because this ratio enables case managers to provide effective case management services. The committee believed that setting a 40:1 ratio in the emergency rule would give counties additional time to move toward the 30:1 ratio projected in the July 1988 fiscal note. Thus, the limit in the initial draft of the emergency rule was modified in response to committee members' requests to find a way to allow counties gradually to move toward full compliance as the counties generated

the additional revenue needed to hire more case managers and achieve compliance.
Item A continues for calendar year 1993 the requirements of the emergency rule relating to the average case manager caseload limit of 40 clients to one full-time equivalent case manager and the criteria for continuing to exceed the case load. See part 9505.0485, subpart 9 [Emergency] which was effective December 27, 1991.
Item B proposes January 1, 1994 as the effective date for the further reduction in caseload size to 30:1 for adults and 15:1 for children.

In preparing the proposed permanent rule on a caseload size limit, the Department has continued to actively seek the participation and advice of many persons and groups. These include the rule advisory committee, the state mental health advisory council and its children's subcommittee, the Minnesota Association of County Social Service Agencies (MACSSA) whose members are the directors, or the designated representatives of the directors, of local social services agencies responsible for implementing case management services under these rules, MACSSA's Rules Committee, providers of mental health services, and client advocates. In addition to face-to-face discussions between the Department and these persons and groups, the Department has distributed several rule drafts to them with a request for their review and comments. Some persons saw a need for striving to attain an ideal caseload of no more than 10:1 for services to children or no more than 25:1 for services to adults. County representatives reported their obligation to consider a reasonable limit and yet to stay within county resources and to obtain the approval of their county boards for both staffing and funding resources. A recent report of county case management caseload size shows a wide range with the average being 42 clients to 1 case manager (42:1). See attachment 3. Similar data are not yet available for children but the limited data available appear to show that most caseloads of children's case managers are in the 20's.
The Department also has reviewed recent reports for possible recommendations. The following reports reflect trends in the current literature on caseload size limits for children's case managers.

. Deinstitutionalization of Mentally Ill People, a report prepared by the Program Evaluation Division, Office of the Legislative Auditor, State of Minnesota, February 1986, commented that the mental health professionals interviewed during the study recommended caseload of 30 clients. The report also commented on a 1979 evaluation of a Hennepin County Community Suport Project, begun in 1978, which found that after one year hospitalization rates were lower for clients receiving more intensive, specialized case management than for clients receiving less intensive, generalized service and that clients receiving the more intensive services reported increased satisfaction with their case management.

. Guidelines for Planning and Implementing Case Management Systems under Public Law 99-660, Title V states:

> The most critical aspect of a case managment system that is successful in attaining client-based outcomes is caseload size. The size of a caseload for a given case manager should be based upon the amount of support needed by the individuals served. Intensive case management services ...are being provided.. [to]..high risk clients..on a 1:10 ratio.

.....

> What is an optimum caseload size for what type of clients..is an issue which is crucial to planning and implementing case management systems but one on which little reliable data are available....The experience of most Workgroup members is that most case management caseloads are far too large. This means that case managers are not able to meet client goals and outcomes and may result in more frequent crises for the client or more inpatient and emergency room admissions.

The most recent federal review of Minnesota's State Mental Health Plan under Public Law 99-660 raised significant concerns about the state's progress in implementing the statutory requirement for the provision of case management services. The state plan was submitted to the National Institute of Mental Health in September 1991. The federal review states, "....caseload size (46:1) is recognized as the most significant problem. ... Rule 74 will reduce this to 40:1, which the reviewers consider to be high....." The summary further states, "Reviewers recommend that the State continue to push for reallocation of funding to reduce the caseload levels to at least 40:to 1 when Rule 74 is revised in February 1992." (See part 9505.0485, subpart 9 [Emergency], effective 12-27-91.) Under P.L.99-660, the State Plan must contain quantitative targets to be achieved in the implementation of a community-based system [including case management services] of care for adults with serious and persistent mental illness or children with severe emotional disturbance. The plan must require the provision of case management services to each such individual in the State who receives substantial amounts of public funds or services. See section 1912 (b)(7)(A) of the 1992 amendment of P.L.99-660. If the State fails to comply with the agreed to plan, the United States Secretary of Health and Human Services may, in whole or in part, suspend payments under the federal mental health block grant, terminate the grant for cause, or employ other remedies available under the law including requiring repayment of funds with interest or offsetting the repayment amount against any future grant to the State. See section 1945 of the 1992 amendment of P.L. 99-660. The Department notes that 1992 amendments to Public Law 99-660, which sets the standards for block grants of federal monies for community mental health services such as case management services, have delayed the deadline for compliance with the standards for case managment services for one year, that is, until September 30, 1993.

The Department also reviewed recent literature related to mental health services including case management services.
The Vermont System of Care Plan for Children and Adolescents Who Are Severely Emotionally Disturbed and their Families, a publication of the Vermont Department of Mental Health and Social and Rehabilitation Services and the Vermont Department of Education, January 1991, supports the proposed caseload size in its statement on page 70:

> Case management and networking focus on coordinating more than one agency or service system; therefore, clear assignment of responsibility is essential. Given the multiple needs of severely emotionally disturbed youth, the seriousness of their problems, the frequency with which crises develop, and the high cost of failure, it is important to keep the case loads of case managers relatively small (e.g.,10 - 15 cases)."

Child and Adolescent Case Management, A Discussion Paper, prepared by the Ohio Department of Mental Health, July 1988, states that the task force formed by the Ohio Case Management Work Group recommends case management caseloads of 1:15. (ibid, pp.13 and 17.) According to this publication, the Child and Adolescent Service System Program (CASSP) recommends that a case manager's caseload should not exceed a ratio of 1:15 although actual caseloads may vary depending on the mix of individuals and their needs. (ibid, p. 6.) The paper states on page 6:

> ...in general, the lower the ratio the more comprehensive and the available the service can be. While this ratio may be difficult to attain initially, systems should be working toward this goal. Considerable time is required to coordinate and collaborate with other individuals and/or systems involved with youth.....A criticism of large caseloads is that they can result in only cursory involvement that is crisis in nature as opposed to ongoing support and accessibility.

Additional recommendations about caseload sizes of children's case management have been made as follows:

. The Children's Subcommittee of the State Advisory Council on Mental Health reached a consensus that "caseloads of 30 or more are unwieldy and work counter to the central idea of case managment." The Subcommittee preferred that caseloads for children's case management not exceed 15.

. Kansas Case Management Progam Standards for Children and Adolescents which states, "Generally, one full time case manager working with children/adolescents will not have a caseload larger than 15." The standards acknowledge variances from this recommendation dependent on intensity of the clients' needs for services.

. North Carolina in a Memorandum of Understanding between Division of Medical Assistance and Division of MH/MR/SAS Area Mental Health Centers set a maximum monthly caseload per FTE staff of 15 Medicaid clients who are emotionally disturbed children and youth.

. Hillsboro County, (Tampa), Florida recommends having a limited caseload sizes for children of 10-20 and "having the time and ability to go in the home, the school and to visit the residential placments to assess and coordinate services."

Additionally, in developing a caseload size limit for children, the Department compared the case management requirements set forth in the Minnesota comprehensive children's mental health act to the model espoused in the monograph A System of Care for Severely Emotionally Disturbed Children and Youth (Stroul, B. A. and Friedman, R.M., Washington, D.C., CASSP Technical Assistance Center, 1986). See Attachment 4. This monograph was written in collaboration with the Child Adolescent Service System Program, (CASSP), Technical Assistance Center of Georgetown University and the Florida Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children at the Florida Mental Health Institute. The CASSP model of services to children and youth is based on using local community resources to work directly with the child with severe emotional disturbance and the child's parents in a coordinated manner. This coordinated approach enhances the potential to avoid fragmentation and omission of services needed the child and the child's family because of the child's emotional disturbance. The coordinated approach encourages the child and the child's parents to have a better understanding of the roles of all of their service providers and how the providers' efforts fit together to meet their needs. Whether a

consolidated agency, lead agency or multiagency management model is used, case managers see to it that the various service components are coordinated and that service needs are assessed and reassessed over time. Stroud and Friedman state that "there are increasing indications that case managers are a key component of any attempt to make a system truly responsive to the needs of the individuals it is designed to serve." This model has been recommended for Minnesota's case management services to children with severe emotional disturbance by the Children's Subcommittee on Mental Health of the State Advisory Council on Mental Health. In commenting on Behar, L.B., (1986), A model for child mental health services: The North Carolina experience, Stroul and Friedman state on page 95:

> Given the multiple needs of severely emotionally disturbed children, the seriousness of their problems, the frequency with which crises develop, and the high cost of failure, it is important to keep the caseloads of case managers relatively small. By increasing success rates, small caseloads may actually enhance the cost-effectivenss of the services. Although there are no carefully tested standards with regard to caseload size, it is generally recommended that they be in the range of 10 to 15 cases per worker. In the North Carolina Willie M. program, each case manager has a caseload of 12 to 15 cases.

The following reports reflect current trends on recommendations about caseload size for case managers of services to adults with serious and persistent mental illness.

. Report on the Ombudsman Advisory Committee's Public Meetings on Case Management Services, Office of the Ombudsman for Mental Health and Mental Retardation, State of Minnesota, January 1991, stated that there "seemed to be some agreement that the maximum caseload size should be 35 clients, as the services are currntly constituted." The report found that caseload sioze varied from 35 to 60 clients. It stated further, "If a more holistic approach were chosen with case managers providing some services, a caseload limit of 25 clients would be more appropriate." The Department notes that at the time of the report in 1991 the service model did not include the provision of direct services by a case manager to his or her case management client. Proposed parts 9520.0900 to 9520.0926 will permit the case manager to provide other mental health services to case management clients if the case manager meets at least the minimum qualifications required to provide the service. See proposed part 9520.0922

. Goldstrom, Ingrid and Ronald W. Mandersheid , A Descriptive Analysis of Community Support Program Case Managers Serving the Chronically Mentally Ill, Community Mental Health Journal, pages 17 to 26, Vol. 19 No.1. Spring 1983, report their study found, "On the average, case managers have 29 CSP clinets and five non-CSP clients in their caseload and spend about one-third of their time in direct service delivery.

. The Memorandum of Understanding, State of North Carolina, cited above, agreed to a maximum monthly caseload per FTE staff of 20 Medicaid clients of eligible mentally ill adults.

In addition to reviewing the literature and considering advice and information from the persons and groups mentioned above, the Department has reviewed the mission statement of the Minnesota comprehensive adult mental health act (section 245.461, subdivision 2, clause (6)) which requires the commissioner to provide "a quality of service that is effective, efficient, appropriate,

and consistent with contemporary professional standards in the field of mental health." The Department has attempted to balance recommendations of advocates for adult clients to lower the caseload size against the "reasonable" test set forth in Minnesota Statutes, section 245.4711, subdivision 9.

Thus, in proposing the caseload limit set forth in this subpart the Department has carefully considered many viewpoints. The Department also has carefully borne in mind that rules are required to set minimum standards. A county may set higher standards and thus exceed the minimum standards set in the rule. The minimum standards in the rule must be consistent with statutes. Because the advisory committee did not reach a consensus on a minimum standard applicable to caselod size limit, the Department has attempted to comply with Minnesota Statutes, section 245.4881, subdivision 1 which requires a ratio "sufficient to meet the needs" of children and section 245.4711, subdivision 9, clause (4) which requires a "reasonable caseload limit" for case managers of adults.

As discussed above on page 26, the Department recognizes that county boards may need time to obtain the resources of funding and staffing necessary to achieve compliance with a caseload limit. Therefore, it is necessary to provide an exception from the requirement to avoid placing an undue burden on county boards and yet at the same time assure that county board will move toward meeting the standard. County boards may exceed the stated ratio, but only to the extent that their revenue is insufficient to hire additional case managers needed to meet the required ratio. This is reasonable because it is consistent with Minnesota Statutes, sections 256E.07 and 256E.081. The exception also is reasonable as it recognizes that county monies are limited, it mitigates the burden placed on counties, and it provides the counties flexibility to adjust their average caseload sizes to their own circumstances.

The terms "increased revenue", "source other than county funds", and "county funds" are terms used in this subpart. Definitions are necessary to clarify their meaning and avoid misunderstanding.

The definition of "increased revenue" clarifies the term's meaning by specifying it is the amount of increase in case management service revenue between a base year and the current calendar year. The Department notes that this definition refers to revenue received for services provided during the relevant year. Counties have up to a year to bill medical assistance (MA) and general assistance medical care (GAMC). The average delay between date of service and date of MA and GAMC payment for case management is about three to six months. For purposes of obtaining MA payment, counties, sometimes, lump billings together with the result that more or less than one year's worth of services may be paid in any given year. Basing the definition on date of service, not date of payment, eliminates the variances that result from the billing and payment process.

The calendar year is used because counties use a calendar year as their fiscal year for budgeting purposes. As a result, county hiring decisions are usually made on a calendar year basis as part of the budgeting process.

Calendar year 1990 is used as the base year since this is the year immediately preceding the legislative mandate to set caseload limits. (See Laws of 1991, Chapter 292, Article 6, Sec. 5.) About one week after the legislative mandate was passed, the Department sent counties Instructional Bulletin #91-53B (dated June 12, 1991), which instructed counties about planning the mental health

component and budgets of their 1992-1993 coomunity social service plan and stated, in part:

> Counties should budget additional MA/GAMC case management revenue as a result of 1991 legislative changes. MA coverage for mental health case management (Rule 74) is expanded to include in-county travel, effective immediately. However, the Legislature also directed the Department to revise Rule 74 by July 1, 1992, including a reasonable limit on caseload size. Counties should plan to spend all of the additional MA/GAMC case management revenue to comply with rule revisions, particularly for additional case managers to reduce caseload size. ....
> Counties should include in their CSSA plan increased revenues and expenditures for MA/GAMC case management, Rule 12/14 grants, and children's grants (family community support services and non-MA case management) ...

As noted in the above bulletin, the Legislature provided for a significant increase in Medical Assistance payments, effective June 1991. In addition, the Department had a number of training and administrative efforts under way to assist counties to increase their billings (and thereby receive additional MA and GAMC revenue) during 1991 and 1992. The Department's fiscal note for the 1991 legislation stated that the proposed legislative changes would be paid for through these additional MA and GAMC payments, and through funds available under the new grant program for services to children. The 1991 Legislature appropriated funds for a new grant of $1,000,000 per year for children's case management, effective April 1, 1992.

In order to implement legislative intent, the Department issued the June 1991 bulletin as soon as possible in order to ensure that any new case management revenue received by counties during 1991 and subsequent years was in fact dedicated to providing improved case management, and not diverted to other purposes.

An argument can be made that the base year for defining "increased revenue" should be 1987, the year in which the original mandate for case management was passed in the Comprehensive Mental Health Act. Or 1988 could be used, the year immediately preceding the beginning of MA payments for case management services. The July 1988 fiscal note for the original Rule 74 assumed that full compliance with the original Rule 74 would require reduction of average caseload sizes to 30:1, and that the new Medical Assistance payments (as approved and budgeted by the 1987 Legislature) would allow hiring of additional case managers to serve additional clients and reduce caseload sizes to 30:1. See appendix xyz.

The Department notes that the proposed rules use a past year only for the purpose of defining "increased revenue" in a future year. This is not a retroactive requirement to change anything in the past. The requirement is simply that increased revenue received for future years must be used to move towards compliance with the caseload limits.

After a county achieves compliance with the average caseload size limit, a county is required to remain in compliance but may apply new increases in revenue as the county deems appropriate.

The definition, "source other than county funds" clarifies the term's meaning

within this subpart. Some clients receiving case management services are eligible for medical assistance, general assistance medical care, or mental health service coverage from a third party payer. The cost of case management services to these clients may be paid from these sources. To the extent that these payments are available they provide a source of payment other than county funds. Thus the definition is reasonable as it is consistent with circumstances. The Department notes that during state fiscal year 1992, there is temporary statutory authority for broader general assistance medical care coverage. However, this coverage is restricted effective July 1, 1992 to persons who would be eligible for medical assistance except that they reside in an institution for mental diseases. See Minnesota Statutes, section 256D.03, subdivision 4, paragraph (a), clause (18) as amended in 1991 and 1992. Even though counties received additional funding under broader GAMC coverage for state fiscal year 1992, this additional funding is not included in this definition because its temporary nature is a barrier to its use for hiring permanent staff.

The definition of "county funds" is reasonable as it is consistent with the cited statutes which authorize funds to be made available to the counties to fund county social service programs according to local needs and priorities.

9520.0904 OUTCOMES OF CASE MANAGEMENT SERVICES TO CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE.

This part of the rule specifies desired outcomes for children with severe emotional disturbance and their families.

Proposed parts 9520.0900 to 9520.0926 are the first outcome based mental health rules in Minnesota. The Department's consultant, Dr. Patton, advised that there have been very few efforts to use outcomes in rules in place of process. Proposed parts 9520.0900 to 9520.0926 represent the Department's "best effort" at stating some outcomes and retaining some "mandates" or process requirements to the extent necessary for quality assurance and monitoring. Proposed parts 9520.0900 to 9520.0926 therefore are a blend of outcome and process.

It is necessary to list the desired outcomes of case management services in order to inform both clients and providers of the goals or outcomes of case management services. Using an outcomes approach is reasonable because it is consistent with professional literature related to case management services; the Governor's Executive Order 91-12 to simplify and eliminate prescriptive rule requirements; the Department's policy direction based on the intent of Minnesota Statutes, section 256E.081, subdivision 3, which under certain specified circumstances, permits the county to amend its social services plan for the purposes of identifying administrative rules requirements with which it will not comply; and improved service delivery.

One of the major reasons for an outcome-based approach is to improve service delivery by allowing counties and individual case managers more flexibility and greater ability to serve their clients. Individual differences exist among a case manager's clients in regard to their mental health status, service needs, ability to communicate and work with the case manager. The case manager is the person in the best position to determine the most effective approach to the client. Requiring outcomes rather than specific processes allows the case manager to select the approach most suited to the client's needs. Thus, an outcomes focus provides an opportunity to improve

service delivery to the client. Similarly, a county is in the best position to know county circumstances, who its clients are and their needs, and the resources available to meet the clients' needs. Thus it is reasonable to use an outcomes focus because it allows the county the flexibility to select the approach most suited to the county's circumstances.

In developing the outcomes proposed in this rule, the Department reviewed some literature on case management service outcomes. Although the literature related to case management services outcomes for children is not extensive, it provided some suggestions that could be adapted for services outcomes for both children and adults.

Child and Adolescent Case Management, (hereafter identified in the SNR of this part as Paper) op. cit., page 13, states:

> As with most programs and services, the issue of outcomes is a difficult one. It is helpful in this discusssion to keep the essential outcome in mind, the one which not only drives the case management process, but is the reason for case management and that is: improvement in the quality of life for the individual.

Paper reports a set of outcomes for both the individual receiving the case management services and the system providing the services. Because this is the Department's first proposed rule to include outcome standards, the Department is proposing systems-based outcomes. The use of outcomes in place of procedural requirements does not remove the Department's responsibility to require fiscal and program reports of the counties and service providers as required under Minnesota law. See Minnesota Statutes, section 245.487, subdivision 3, which requires the commissioner to create and ensure a unified, accountable comprehensive mental health service system. Also see Minnesota Statutes, section 245.4886 subdivision 2 which authorizes the commissioner to require collection of data and periodic reports which the commissioner deems necessary to demonstrate the effectiveness of a service in realizing the purpose as stated for case management in section 245.4881. See for example part 9520.0920 which further details recordkeeping and report requirements.

Systems-based outcomes for children may include according to Paper:

- increased coordination and integration of services;
- caseloads of 1:15;
- family and youth participation in all phases of case management;
- frequency, duration and intensity of case manager's contact with the youth and family;
- frequency and duration of case manager's contact with other systems;
- increased funding for child and adolescent services;
- youth and family satisfaction with services.

Other literature about outcomes places heavy emphasis on the satisfaction of the child and the child's family as measured through surveys and personal interviews of the child and the child's family.

The outcomes proposed in parts 9520.0904 and 9520.0905 were developed by members of the advisory committee with the assistance of the Department's consultant, Dr. Patton. After an initial presentation to the advisory committee on developing outcomes appropriate for case management services, Dr. Patton met with a Task Force chosen from the advisory committee members for the purpose of developing outcomes to include in the proposed rules. The members of the Task Force were representative of the categories of the committee's membership and included case manager, case manager supervisors,

mental health practitioners and professionals, client advocates, and county directors or their representatives named by the Minnesota Association of County Social Services Administrators. The Task Force achieved a consensus and recommended to the advisory committee that the overall goal of case management should be the client's improved or maintained mental health and functioning. The advisory committee accepted this recommendation. Requiring the case manager to use a process designed to assist the child with severe emotional disturbance to pursue the outcome of improved or maintained mental health and functioning is reasonable because it is consistent with the purpose of assisting the child to function and remain in the community with the child's family as set forth in Minnesota Statutes, section 245.4871, subdivision 17. It also is consistent with Minnesota Statutes, section 245.4881, subdivision 5 which requires ongoing contact and coordination between the case manager and the family community support services as well as other mental health services for each child.

The Task Force also reached a consensus and recommended to the advisory committee that other outcomes should be those specified in items A to G of part 9520.0904, in the case of children, and in items A to H of part 9520.0905, in the case of adults were important to assist the child or adult to improve or at a minimum maintain the client's mental health and functioning. These recommendations also were accepted by the advisory committee.

Item A. This item is consistent with Minnesota Statutes, section 245.487, subdivisions 2 and 3, clauses (3)(ii), (5), and (7). Subdivision 2 states:

> Although the services specified in section 245.487 to 245.4888 are mental health services, sections 245.487 to 245.4888 emphasize the need for a child-oriented and family-oriented approach of therapeutic programming and the need for contnuity of care with other community agencies.

Subdivision 3 states in clauses (3)(ii), (5), and (7):

> ....the commissioner of human services shall create and ensure a unified, accountable, comprehensive children's mental health service system that...assures access to a continuum of services that...address the unique physical, emotional, social, and educational needs of children....provides mental health services to children and their families in the context in which the children live and go to school...and includes the child and the child's family in planning the child's program of mental health services, unless clinically inappropriate to the child's needs;

Thus the legislature emphasized the need for child-oriented and family-oriented services. The involvement of the family will enhance the delivery of services for their child. Services must be provided in an environment that allows the child to live at home and participate in school and community activities. A child and family-focussed approach also is based on the collaborative research done by the Child Adolescent Service System Program at Georgetown University Child Development Center and the Florida Research and Training Center for Improved Services for Seriously Emotionally Disturbed Children, the Florida Mental Health Institute, as set forth in A System of Care for Severely Emotionally Disturbed Children and Youth. See proposed part 9520.0902, subpart 6 which defines "case management team" and part 9520.0916 which sets forth the duties and responsibilities of the team.

Definitions of the terms "child-centered", "family-focused", and "community-based" are necessary to clarify their meaning and set a standard. The definitions are reasonable as they are consistent with Minnesota Statutes, section 245.487, subdivisions 2 and 3, clauses (3)(ii), (5), and (7). Minnesota Statutes, section 245.4876, subdivision 1, clause (2) states that children's mental health services "must be based on individual clinical, cultural, and ethnic needs, and other special needs of the children being served." Clause (9) of subdivision 1 states that children's mental health services "must be appropriate to the developmental age of the child being served." Thus it is reasonable to define child-centered as based on and adapted to the individual needs of the child and the child's family as the definition is consistent with clauses (2) and (9) of subdivision 1.

Minnesota Statutes, section 245.4876 , subdivision 1, clause (3) requires children's mental health services to be "delivered in a manner that improves family functioning when clinically appropriate." Clause (11) of subdivision 1 requires the services to be "provided in a manner ....most likely to facilitate progress toward treatment goals." With very limited exceptions, a child lives within a family or a foster family setting. Involving the child's family in the planning and delivery of services will assist the family in understanding the child's needs, treatment goals, and services, which will increase the likelihood the family will be willing and able to assist in meeting the child's needs and accessing the child's services. Furthermore, unless the child meets the exceptions specified in part 9520.0907, authorization for the child to receive services must be obtained from the child's parents or legal representative. Requiring family-focused services is reasonable as it is consistent with the requirements of Minnesota Statutes, section 245.4876, subdivision 1, clauses (3) and (11).

The definition of community-based is reasonable as it is consistent with Minnesota Statutes, section 245.4876, subdivision 1, clause (4) which requires children's services to be "provided in the most appropriate, least restrictive setting available to the county board to meet the child's treatment needs." The definition of "community-based" is consistent with Minnesota Statutes, sections 245.4882, subdivision 3 and 245.4883, subdivision 1.

Item B. This item is consistent with Minnesota Statutes, section 245.4876, clause (2) which requires children's mental health services to be based on the "individual clinical, cultural, and ethnic needs, and other special needs of the children being served." See also Minnesota Statutes, section 245.487, subdivision 3, clause (v). Client advocates and agencies serving children have told the Department that children of minority heritage are not always served as effectively as other children. Therefore, they have supported the concept of using special mental health consultants to assure the appropriateness of case management and other mental health services to children of minority heritage. The item is reasonable because the use of special mental health consultants is related to increased service appropriateness and effectiveness.

Item C. This item specifies that the case manager must use a process that results in the child's parent or legal representative or, as appropriate, the child, receiving certain information. This item is reasonable because it is consistent with the notification requirements in Minnesota Statutes, section 245.4881, subdivision 2, paragraph (b) It also is reasonable because

receiving information about eligibility for service, availability of services and service benefits provides an opportunity for the child's parent and the child to understand the nature of the service and decide whether to give an informed consent to services pursuant to Minnesota Statutes, section 245.4881, subdivision 2, paragraph (c). See also Minnesota Statutes, section 245.4874, clause (4) which requires a county board to "assure that the parents...in the county receive information about how to gain access to services provided [under the Minnesota comprehensive children's mental health act.]" See parts 9520.0906, subpart 1 and 9520.0908.

Item D. This item is reasonable because it is consistent with Minnesota Statutes, section 245.4871, subdivision 3, which states that case management services are activities designed to help the child and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and certain related services. See part 9520.0914, subpart 1.

Item E. Item E is reasonable because it is consistent with Minnesota Statutes, section 245.4873, subdivision 4 which states that the case manager is responsible for ongoing coordination with any other person responsible for the planning, development, or delivery of services for the child. See also Minnesota Statutes, section 245.4881, subdivision 5 which requires "procedures that ensure ongoing contact and coordination between the case manager and the family community support services as well as other mental health services for each child." Simplifying a child's access to the services, bringing together similar services in a manner that eliminates duplicative services and assures continuity of needed services are reasonable requirements because they are consistent with Minnesota Statutes, section 245.4876, subdivision 1, clauses (7) and (9) which require continuity of and coordination of services to the child. See parts 9520.0914, subpart 2, item A(4) and 9520.0920, subpart 2, item B.

Item F. The Minnesota Government Data Practices Act, the Patients and Residents of Health Care Facilities Bill of Rights, Minnesota Statutes, sections 144.651, subdivisions 1, 3 to 16, 18, 20, and 30, and Minnesota Statutes, section 256.045 specify certain requirements for providers of client services. Requiring the process used to provide information about these statutes is consistent with the statutes. See parts 9520.0914, subpart 2, item A(10) and 9520.0920, subpart 2, item E.

Item G. Item G is reasonable because it is consistent with Minnesota Statutes, section 245.4881, subdivision 3 which requires the case manager to develop an individual family community support plan for the child receiving case management services. The item also is consistent with Minnesota Statutes, section 245.4881, subdivision 4 and section 245.4871, subdivision 19, which require the case manager to develop the individual family community support plan on the basis of a diagnostic assessment and a functional assessment of the child. Minnesota Statutes, section 245.4881, subdivision 4, paragraph (b) requires the plan to state "(1) the goals and expected outcomes of each service and criteria for evaluating the effectiveness and appropriateness of the service". See part 9520.0918.

9520.0905 OUTCOMES OF CASE MANAGEMENT SERVICES TO ADULTS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

This part sets forth outcomes of case management services for adults with serious and persistent mental illness. This part is necessary to list the

desired outcomes in order to inform clients and providers of the goals or outcomes of case management services.

See the discussion of outcomes in the SNR of part 9520.0904 above. The advisory committee after reviewing the recommendations of its outcomes task force recommended the inclusion of the specific outcomes in items A to H for adults in addition to the overall outcome of improved or maintained mental health functioing.

Items A to H are necessary to specify the outcomes that the case manager must address in the process designed and implemented under this part.

Item A. This item stating that the client's services must be client-centered is consistent with the definition of an individual community support plan, found in Minnesota Statutes, section 245.462, subdivision 12 which specifies the services the client needs. Subdivision 12 states that the client's plan must be based on the adult's diagnostic assessment and functional assessment. Thus, statute requires the plan to be client focussed. Item A also requires the services to be community- based. This requirement is consistent with Minnesota Statutes, section 245.467, subdivision 1, clause (3) which requires mental health services to be provided in the most appropriate, least restrictive setting. Definitions of the terms "client-centered" and "community-based" are necessary to clarify their meaning for purposes of these rules.

The definition of "client-centered" is consistent with Minnesota Statutes, section 245.467, subdivision 1, clause (2) which requires mental health services provided by a county to be "based on individual clinical needs, cultural and ethnic needs, and other special needs of individuals being served."

The definition of "community-based" is consistent with Minnesota Statutes, section 245.467, subdivision 1, clause (3) which requires services provided by the county board to be in the most appropriate, least restrictive setting available to the county board. The definition also is consistent with Minnesota Statutes, sections 245.472, subdivision 3 and 245.475, subdivision 3.

Item B. This item is reasonable because it is consistent with the requirement of Minnesota Statutes, section 245.4711, subdivision 4, that, "to the extent possible", the adult's "family, advocates, service providers, and significant others" be "involved in all phases of development and implementation of the adult's individual support plan. See part 9520.0914, subpart 2, item B(4).

Item C. This item is reasonable because it is consistent with Minnesota Statutes, section 245.467, subdivision 1, clause (2). Under clause (2), a county's mental health services must be "based on the individual clinical needs, cultural and ethnic needs, and other special needs of individuals being served." Client advocates and case managers serving adults have told the Department that persons of minority heritage are not always served as effectively as others. Therefore, they have supported the concept of using special mental health consultants to assure the appropriateness of case management and other mental health services to adults of minority heritage. The item is reasonable because the use of special mental health consultants is related to increased service appropriateness and effectiveness.

Item D. This item is reasonable because the information is required to make an informed decision case management services and other mental health services. See Minnesota Statutes, section 245.4711, subdivision 2 which

requires a written notice from the county to the adult about the adult's potential eligibility for services and designated case managers. See parts 9520.0906, subpart 1, 9520.0908, and 9520.0914, subpart 1.

Item E. This item clarifies the case manager's role about assisting the client to access the services specified in the client's individual community support plan. The item is reasonable as it informs affected persons and thereby reduces the possibility of misunderstanding. See Minneosta Statutes, section 245.462, subdivison 3 which states that case management services are activities that are designed to help adults in gaining access to needed mental health and other services and include the development of the adult's individual community support plan. See part 9520.0914, subpart 1.

Item F. This item is reasonable because it is consistent with Minnesota Statutes, sections 245.462, subdivision 3, which requires case management services to be coordinated with community support services, with section 245.467, clause (7), which requires mental health services to be coordinated with mental health services offered by other providers, and with section 245.4711, subdivision 9 that rules governing case management services establish a comprehensive coordination of services. Additionally it is reasonable because it requires administrative implementation of section 245.4711, subdivision 5, which requires county procedures that ensure ongoing contact and coordination between the case manager and the community support services program as well as other mental health services. Continuity is a component of coordination that assists the provision of services in an ongoing, comprehensive manner and avoids gaps in the services needed by the client. Coordination of services for an adult also improves the availability of services by removing barriers to services as similar services are brought together and access to them is simplified. Furthermore bringing similar services together reduces possibly repetitive staff efforts or duplicative services, thereby aiding cost effectiveness and maximizing the availability of funds to pay for case management services. See part 9520.0920, subpart 2, Item B.

Item G. Minnesota Statutes, section 245.467, clause (8) requires mental health services to be "provided under conditions which protect the rights and dignity of the individuals being served." The individuals being served, the adults with serious and persistent mental illness, need the information required under this item to become informed. The Minnesota Government Data Practices Act, the Patients and Residents of Health Care Facilitites Bill of Rights set forth in Minnesota Statutes, sections 144.651, subdivisions 1, 3 to 16, 18, 20, and 30 and Minnesota Statutes, section 256.045 specify certain requirements for providers of client services. Because case managers have access to this information, it is reasonable to require design and implement a process that includes the outcome of providing the information about these requirements.

Item H. Minnesota Statutes, section 245.4711, subdivision 4, paragraph (a) requires that the case manager develop an individual community support plan for the adult receiving case management services based on the adult's diagnostic assessment and a functional assessment. Paragraph (a) also states that the case manager is responsible for monitoring the delivery of the services in the plan. Minnesota Statutes, section 245.4711, subdivision (4), paragraph (b) requires the plan to state the goals of each service and the activities for accomplishing each goal. Minnesota Statutes, section 245.4711,

subdivision 3 requires the case manager to complete a functional assessment of the adult. Thus this outcome is reasonable as it is consistent with the statutory requirements and informs affected persons. See part 9520.0919.

9520.0906 LOCAL AGENCY RESPONSIBILITIES; NOTICE AFTER REQUEST OR REFERRAL FOR SERVICES

The Legislature has specified in statute numerous required procedures relating to case management services. The following parts 9520.0906 to 9520.0926 derive from and furhter explain these statutory requirements.

It is necessary for the local agencies to have a procedure to assist the persons who are referred for or request mental health services to access those services. Part 9520.0906 specifies the procedure to accomplish this purpose.

Subpart 1. Notice following request or referral for services.

This subpart is necessary to inform affected persons of the requirements for notices as specified in statutes. See Minnesota Statutes, section 245.4881, subdivision 2 which requires notices related to services to children to be sent "as, appropriate, [to] the child, child's parent, or legal representative....within five days after receiving a request ...or referral.." for case management services for the child. Minnesota Statutes, section 245.4881, subdivision 2 also requires the notice to contain information about the "child's potential eligibility;" to be "written in plain language;" to "identify the designated case management providers;" and "to contain a description of case management and family community support services, the potential benefits of these services, the identity and phone number of the county employee designated to coordinate case management activities, an explanation of how to obtain county assistance in obtaining a diagnostic assessment, if needed, and an explanation of the appeal process." Minnesota Statutes, section 245.4711, subdivision 2 although not identical to Minnesota Statutes, section 245.4881, subdivision 2 contains similar requirements for adults. The proposed rule applies the same standards for notice to both children and adults. This is reasonable because a single standard promotes administrative efficiency and avoids misunderstanding. Requiring the notice, in the case of a child, to state that the county will assist the person to whom the notice is addressed to contact a special mental health consultant is reasonable as it is consistent with Minnesota Statutes, section 245.4874, clause (13). Clause (13) requires a county board to "assure that special mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage." See the definition of minority race or minority ethnic heritage in part 9505.0902, subpart 31. See also Minnesota Statutes,sections 245.487, subdivision 3, clause (3)(v) and 245.4876 (2).

Subp. 2. **Notice when there is no known address.** This subpart is necessary because some persons who are eligible for case management services do not have a permanent mailing address. It is reasonable to require that the local agency make a reasonable attempt to locate these persons. This subpart continues a requirement set forth in the present rule related to case management services, part 9505.0480, subpart 3, (which will be repealed upon the adoption of this rule.) This subpart is consistent with the requirement of Minnesota Statutes, sections 245.4871, subdivision 17, clause (1) which

specifies client outreach as a component of family community support services for children with severe emotional disturbance and with Minnesota Statutes, section 245.4878, clause (2) which requires counties to provide early identification and intervention services to children. See also Minnesota Statutes, section 245.462, subdivision 6 which specifies client outreach as a component of community support services for adults with serious and persistent mental illness.

Subp. 3. **Follow-up notice of availability of case management services.** This subpart is necessary to encourage persons who are eligible for case management services to avail themselves of those services. It is reasonable to require a follow-up to parents of children with severe emotional disturbance because parents have requested this additional contact. According to the parents of children with severe emotional disturbance who are members of the State Subcommittee on Children's Mental Health, many parents who want to help their children are reluctant to accept needed services because in the past their children were separated from them to receive the needed services and because in the past families were not given information to assist their understanding of the child's emotional disturbance and need for services or they were not given an opportunity to participate in planning their child's services.

It is reasonable to require the local agency to follow-up in the case of an adult, because the adult's mental illness may interfere with the adult's ability to respond appropriately to the offer of case management services without further assistance. Additional follow-up for both children and adults is consistent with Minnesota Statutes, sections 245.4871, subdivision 17, clause (1) and 245.462, subdivision 6 which specify client outreach as a component of community support services.

It should be noted that this subpart does not specify how or when the local agency must attempt to contact the adult or the child but only that the local agency must make a "reasonable attempt". The intent of the rule is to provide the local agency flexibility to use the means most appropriate to that local agency and its clients. Requiring a "reasonable attempt" or "allowing some flexibility" is reasonable as the local agency is in the best position to know local circumstances and agency clients.

9520.0907 **PERSON TO RECEIVE NOTICE AND AUTHORIZE SERVICES**

This part is necessary to establish who has the right to receive notice and to authorize services for a child. This part continues without substantive change present part 9505.0480, subpart 5, which will be repealed upon the adoption of part 9520.0907. This part is consistent with Minnesota Statutes, sections 245.4881, subdivision 2, paragraph (c) and 245.4876, subdivisions 4 and 5.

As stated in the SNR of present part 9505.0480, subpart 5 when it was proposed at public hearing, a child's parent or legal representative has the responsibility to provide for the safety, health, and well being of the child. This responsibility includes making decisions about the need for, type of, and source of the child's services including mental health services such as case management. It is the right of the parent to receive the information about the child and services available to the child necessary for the parent to make an informed choice. However, certain circumstances affect the parent's rights and responsibilities in regard to the child. This part establishes that parents are entitled to receive notices about services available to the child except under certain circumstances. In response to a question from the

Revisor of Statutes, the Department has carefully reviewed Minnesota Statutes, section 253B.03, subidivision 6 which allows a minor patient to consent to hospitalization, routine diagnostic evaluation, and emergency or short-term acute care if the minor is 16 years of age or older. If a committed child is authorized by statute to consent to treatment while in a residential treatment facility, it is reasonable that the rule permit such a child also to consent to case management services. This also is consistent with part 9520.0914, subpart 2, item A, subitem (7) which requires a case manager to take part in discharge planning for a child who is in a residential treatment facility.

9520.0908 CONTACT BETWEEN PERSON DESIGNATED BY COUNTY BOARD TO COORDINATE CASE MANAGEMENT SERVICES AND CHILD'S PARENT AND CHILD OR THE ADULT

Minnesota Statutes, section 245.4876, subdivision 4 requires that, if a parent or child consents to services or authorizes a release referral for case management services, a provider must notify the county employee designated by the county board to coordinate case management activities of the child's name and address. Part 9520.0908 is necessary to set forth the duties of the county employee designated to coordinate case managment services once a referral or a request has been received and consent to the services has been obtained. Requiring the county employee to contact the child's parent or legal representative or, if appropriate, the child to explain how to access the services, the need for a diagnostic assessment to determine the child's eligibility, and to assist the child's parent or legal guardian to make an informed choice about whether to obtain the diagnostic assessment required for a service eligibility determination or a review and updating of a previous diagnostic assessment is reasonable as it is consistent with case management services as specified in Minnesota Statutes, section 245.4871, subdivision 3. It also is consistent with Minnesota Statutes, section 245.4876, subdivision 4 which requires the consent of the child's parent or legal representative or, if appropriate, the child to be referred to a diagnostic assessment provider. Additionally, it is consistent with Minnesota Statutes, section 245.4881, subdivision 2 (c) because it assists the county in making a prompt determination of whether the child meets the case management eligibility criteria under Minnesota Statutes, 245.4881, subdivision 2(c).
Similarly Minnesota Statutes, section 245.4711, subdivision 2 requires the county board to notify the adult who has requested or is referred for case management services of the adult's potential eligibility within five working days after receiving the request or the referral. Also see part 9520.0906. Requiring the person designated by the county board to coordinate case management activities to contact the adult is reasonable as it provides the person opportunity to explain to the potential client how to access the services, the need for a diagnostic assessment or a review and update of a previous diagnostic assessment in order to determine whether the person is eligible for case management services.
This subpart also states that the required contact must take place no later than 15 working days after the local agency receives the request or the referral under part 9520.0906. The interval of 15 days after receiving the request or referral is reasonable as it balances the workload of the county employee and the possible difficulty the county employee may encounter in

contacting the client or, as appropriate, the person able to act on behalf of the client. The interval of 15 days also is reasonable as it assists the county board to meet its obligation to "promptly determine" whether a child who requests or is referred for services meets the criteria of service eligibility. See Minnesota Statutes, section 245.4881, subdivision 2 (c). Using the same standard of 15 days for contacting between the county employee and the potential client is reasonable as it is administratively efficient and avoids confusion.

9520.0909 DETERMINATION OF SERIOUS AND PERSISTENT MENTAL ILLNESS OR SEVERE EMOTIONAL DISTURBANCE; ASSISTANCE IN ARRANGING DIAGNOSTIC ASSESSMENT

Subpart. 1. **General requirement.** Only children who have been determined to have severe emotional disturbance and adults determined to have serious and persistent mental illness and are eligible for mental health case management services. See Minnesota Statutes, sections 245.4874 (6) and 245.4881, subdivision 1 for children and sections 245.465, subdivision 2 and 245.4711, subdivision 1 for adults. This subpart is necessary to set forth a standard for determining whether a child or an adult is eligible for case management services under parts 9520.0900 to 9520.0926. A diagnostic assessment is one means of determining whether a child has a severe emotional disturbance or an adult has a serious and persistent mental illness. Requiring a diagnostic assessment is consistent with Minnesota Statutes, section 245.4881, subdivision 2 in the case of a child and with section 245.4711, subdivision 2 in the case of an adult.
Such an diagnostic assessment includes a summary of the history, diagnosis and general service needs of the individual being assessed. See Minnesota Statutes, section 245.4871, subdivision 11 applicable to children and 245.462, subdivision 9 applicable to adults. Also see the definitions in part 9520.0902, subpart 6. Requiring a diagnostic assessment to determine the person's eligibility for case management services is reasonable as the diagnostic assessment provides the information on which to base a determination of whether the child or the adult meets the eligibility standards for case management set forth in statute and this rule. This subpart also is reasonable as it does not require a completely new diagnostic assessment when it is possible to update a recent assessment, thus safeguarding against unnecessary services while at the same time providing the opportunity to obtain a new diagnostic assessment if the person's mental health status has changed markedly since the previous assessment. According to members of the rule advisory committee, requiring a completely new diagnostic assessment only if one has not been completed within the 180 days previous to the person's request or referral for services is reasonable because it is probable that most of the information obtained in that previous assessment still applies and only a review and update are necessary. The requirement related to updating is consistent with Minnesota Statutes, section 245.467, subdivision 2 which specifies when providers of certain adult mental health services are required to complete an adult's diagnostic assessment. It also is consistent with the updating provisions of Minnesota Statutes, section 245.4876, subdivision 2 which specifies when a child's diagnostic assessment is required.
Subp. 2. **Eligibility if child or adult does not have a current diagnostic**

assessment. There are circumstances under which a child or an adult who is referred for or requests case management services needs, and is willing to accept the services but does not have a current diagnostic assessment as specified in subpart 1. For example, the child or adult may be experiencing a mental health crisis which prevents the child or the adult from obtaining a diagnostic assessment or interferes with the ability of the mental health professional conducting the assessment to obtain the necessary information. This subpart is necessary to specify the circumstances under which a child or and adult may receive case management services if the person does not have a current diagnostic assessment.

Item A is reasonable as it is consistent with Minnesota Statutes, section 245.4881, subdivision 1 and section 245.4711, subdivision 1.

Items B(1) and B(2) are reasonable because they recognize that severe emotional disturbance or serious and persistent mental illness may impair a potentially eligible child's or adult's ability to make decisions about needed services, including the ability to request or consent to a diagnostic assessment.

Item B(3). See part 9520.0906 which specifies the right of the parent to make decisions about a child's services and authorize the releaser of information about the child and the circumstances under which the child's parent no longer has these rights. See also part 9520.0908 which sets forth the requirement that the child's parent, legal representative, or if appropriate, the child has to make an informed choice of whether to obtain the required diagnostic assessment or its review and updating.

However, the parent of a child who is potentially eligible for case management services and who is referred for these services may be unaware of, unwilling, or unable to accept the child's emotional disturbance and therefore the child's need for the services. The parent therefore may refuse to obtain the diagnostic assessment required under subpart 1 to determine the child's eligibility for case management. Case managers and former case managers who assisted the Department in developing the rule reported they have worked with parents who initially refused to authorize a child's diagnostic assessment. They also reported that they as case managers have been able over time to establish a good working relationship with such parents to the extent that the parents later will authorize the child's diagnostic assessment. This subitem is reasonable as it provides an exception that will allow the child to receive a needed service while at the same time providing the case manager an opportunity to explain to the child's parent the services available to meet the child's needs and how to access these services.

For other means of making the determination of severe emotional disturbance and serious and persistent mental illness, see the definition of child with severe emotional disturbance in Minnesota Statutes, section 245.4871, subdivision 6 and also subparts 2 and 3 and the definition of serious and persistent mental illness in Minnesota Statutes, section 245.462, subdivision 20, paragraph (c).

Item C. This item is consistent with Minnesota Statutes, section 245.4781, subdivision 6, clause (1), (2), or (4) which sets out the criteria for children with severe emotional disturbance and with section 245.462, subdivision 20, paragraph (c), clause (1), (2), or (4) which sets out criteria for serious and persistent mental illness. Thus, it is reasonable for the case manager to determine that a person meeting one of these criteria is

eligible for case management services.

Item D. A diagnostic assessment will provide information about the client's current mental health status that is needed for determining whether the client has a severe emotional disturbance or serious and persistent mental illness and for identifying the services needed by the client and the desired service outcomes. Requiring the assessment within four months of the day the person first receives case management services is reasonable as it balances the obligation of the client to comply with the procedure to determine the client's potential eligibility, the time that the case manager may need to establish rapport with the client or the parent of a child or the child, and the need of the case manager to obtain the information summarized in the assessment for the purposes of assisting the client to access to needed services and carrying out the responsibilities of a case manager according to these rules. The rule advisory committee commented that the interval of providing case management services without a new or updated diagnostic assessment is appropriate as it balances the time that may be necessary to establish a good relationship with the client or the client's parent or legal representative and the case manager's need for the information that is available from the diagnostic assessment.

Subp. 3. Assistance in obtaining diagnostic assessment. This subpart is necessary to inform affected persons of the statutory requirement that a county board must offer to assist potentially eligible persons to obtain a diagnostic assessment. The requirement to offer assistance is established in Minnesota Statutes, section 245.4881, subdivision 2, paragraph (c) and section 245.4711, subdivision 2, paragraph (b). Minnesota Statutes, section 245.4876, subdivision 5 requires a county board to obtain the informed consent for services or authorization to release information about a child's mental health services before providing the service or releasing the information. Consent for services and authorization to release information about mental health services to an adult are required under Minnesota Statutes, section 245.467, subdivision 4. Although the statutes cited in this paragraph do not specify the time limit for offering assistance , Minnesota Statutes, section 245.4876, subdivision 2, paragraph (c) does require the county board to "promptly determine whether a child .....meets the criteria" of eligibility for case management services. A standard time limit is necessary to clarify the meaning of "promptly" and assure equitable treatment of all potentially eligible persons. The limit of ten working days is reasonable as it is a balance between the possible workload of the local agency and the need of the persons to obtain timely case management services. The rule advisory committee assisting the Department agreed that ten working days was an appropriate length of time within which the local agency must offer assistance in obtaining an appointment.

Subp. 4. Diagnostic assessment of child of a minority race of minority ethnic heritage. Children referred or requesting case management services may belong to many different minority racial or minority ethnic groups. Minnesota Statutes, section 245.4876, subdivision 1, clause (2) requires children's mental health services to be based on the individual "clinical, cultural, and ethnic needs, and other special needs of the children being served." Minnesota Statutes, section 245.4874, clause (13) requires a county board to "assure that special mental health consultants are used as necessary to assist

the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage." Minnesota Statutes, section 245.487, subdivision 3, clause (3)(v) requires the children's mental health service system to provide services that "are sensitive to cultural differences and special needs."

Children and their parents who belong to cultures that do not fully understand or accept American customs or mental health services may have difficulty obtaining an accurate diagnostic assessment. Services may be desired where the child or parents do not understand English or the questions asked in a diagnostic assessment. Knowledge of these circumstances and skill in adjusting to them will assist the mental health professional providing the diagnostic assessment to obtain the necessary accurate information. Thus it is reasonable to require the mental health professional either to be skilled and knowledgeable in conducting the diagnostic assessment of such a child or to consult a special mental health consultant. See the definition of special mental health consultant in part 9520.0902, subpart 39 and Minnesota Statutes, section 245.4871, subdivision 33a. This requirement also is consistent with recommendations made in the Towards a Culturally Competent System of Care, prepared by the Child Adolescent Service System Program, Technical Assistance Center at Georgetown University Child Development. The report states:

> Psychological testing [diagnostic assessment may include psychological testing] needs to be interpreted in the context of the client's culture..... Other forms of assessment must take precedence over the use of testing with most minority children. Interviewing and gathering collateral information from family and community resources is essential. Persons evaluating minority children should be aware of the behavior typical of bicultural encounter. When a minority family or individual encounters a system or helper who is different than they are, they will exhibit some adjustment behavior to that situation. Interventions can be planned to include the entire family system as defined by the client. In addition, the family system can be viewed in its cultural context."

As stated in Child and Adolescent Case Management, A Discussion Paper, page 9,

> The child ..and family are indispensable and primary resources in identifying what has happened in their lives and what are their needs. The family know more about what has happened with the [child] than anyone else. Thus, the family as well as the [child] are primary resources ...in working with a troubled youngster.

These reports imply that to understand the needs of and help the children with severe emotional disturbance the provider must be able to understand and help the children's families. Knowledge of the ethnic heritage and the subtleties of language used by persons of minority race or minority ethnic heritage in which a child is being raised are essential to understanding the child's circumstances and the needs of the child and the child's family. Therefore, it is reasonable to require the mental health professional conducting the diagnostic assessment of a child of a minority race or minority ethnic heritage to be skilled and knowledgeable about the child's minority race or minority ethnic heritage. However, the mental health professional accessible by the child of a minority race or minority ethnic heritage may not have knowledge necessary to fully understand the circumstances of the child and the child's family. Without complete understanding, it may be impossible to

conduct an appropriate diagnostic assessment. To avoid such an outcome and assure that the diagnostic assessment is relevant, culturally specific, and sensitive to the child's cultural and ethnic needs, it is reasonable to require the mental health professional to consult a special mental health consultant who is skilled and knowledgeable about the child's minority racial and minority ethnic heritage.

9520.0910 DETERMINATION OF ELIGIBILITY FOR CASE MANAGEMENT SERVICES

Subp 1. Local agency determination. This subpart is necessary to inform affected persons of the requirement placed on the county board and delegated by the board to the local agency to determine whether the child or the adult meet the criteria for eligibility established in statutes to receive case management services. See Minnesota Statutes, section 245.4881 and Minnesota Statutes, section 245.4711. See also parts 9520.0902, subpart 7 and subpart 32a. This subpart is reasonable because it is consistent with the cited statutes.

Subp. 2. Notice of determination. Minnesota Statutes, sections 245.4881, subdivision 2, paragraph (c) in the case of a child, and 245.4711, subdivision 2, paragraph (b), in the case of an adult, require the county board to give written notice of the eligibility determination. This subpart is necessary and reasonable because it informs affected persons of the statutory requirement for a notice of the determination of eligibility. The Department notes that the cited statutes applicable to notices of determination do not specify a plain language requirement similar to that for notice of potential eligibility under Minnesota Statutes, section 245.4881, subdivision 2, paragraph (b). Therefore, the Department has chosen not to apply the plain language requirement to a notice of determination.

Subp. 3. Eligible client referred to provider. Minnesota Statutes, section 245.4881, subdivision 2, paragraph (c) in the case of a child, and Minnesota Statutes, section 245.4711, subdivision 2, paragraph (b) in the case of an adult, require a county board to refer a person determined eligible for case management services to a case management provider. This subpart is necessary and reasonable because it informs affected persons of the statutory requirement to refer persons eligible for case management services.

Subp. 4. Referral of adult with mental illness or child with emotional disturbance. A child who is determined not to have a severe emotional disturbance may need other services for which the child or the child's parent gives consent. Likewise, an adult who requests or is referred for case management services may be determined not to have a serious or persistent mental illness. In these cases, the child or adult will not receive case management services but may need and be willing to accept other needed services. Minnesota Statutes, section 245.4881, subdivision 2, paragraph (c) in the case of a child, and section 245.4711, subdivision 2 in the case of an adult requires a county board to offer to refer the child or the adult to a mental health provider or other appropriate service provider and to assist the adult or child in making an appointment with the provider. This subpart is necessary and reasonable because it informs affected persons of the statutory

requirement.

Subp. 5. Refusal. The parent of a child or, as appropriate, the child, who is determined eligible for case management services may refuse the case management services but consent to other mental health services for which the child is eligible. Likewise, an adult who is determined eligible for case management services may refuse these services but be willing to accept other needed mental health services. This subpart is necessary and reasonable because it informs affected persons of the requirement of Minnesota Statutes, sections 245.4711, subdivision 2, paragraph (b) and 245.4881, subdivision 2, paragraph (c) that the county board offer to refer such persons to a mental health provider or other appropriate service provider and to assist in making an appointment with the provider of the client's choice. The Department notes that refusal under this subpart means that at the time a client eligible for case management services was offered the services, the adult or the child's parent or legal representative or, if appropriate, the child refused to accept the case management services. However, a refusal does not mean the client is no longer eligible for case management services. A client continues to be eligible for case management services as long as the client meets the criteria of severe emotional disturbance in the case of a child or serious and persistent mental illness in the case of an adult.

9520.0912 CASE MANAGER QUALIFICATION AND REQUIRED SUPERVISION

Subpart 1. Qualification of case manager; services to a child. This subpart is necessary because it sets uniform standards for qualifications of a case manager. The qualifications set forth in this subpart are the same as those established in Minnesota Statutes, section 245.4871, subdivision 4, paragraph (b). Professionals holding these qualifications may be employed by an agency other than the county board which is part of the local system of care serving children in the county. Paragraph (a) of subdivision 4 permits qualified persons to serve as case managers if they are employed by the county or another agency authorized to provide case management services. Thus this subpart is reasonable as it is consistent with Minnesota Statutes, section 245.4871, subdivision 4, paragraphs (a) and (b).
Several counties have commented to the Department that they believe it is necessary and appropriate only to employ or contract, as case managers, persons who have qualifications exceeding the minimum requirements of Minnesota Statutes, section 245.4871, subdivision 4, paragraph (b). Nothing in the rule prohibits counties from employing or contracting as case managers persons whose qualifications exceed the minimum requirements. The Department believes that requiring qualifications beyond those established by the Legislature would be inconsistent with legislative intent and would place an undue hardship on many counties, especially those in greater Minnesota. These counties might have difficulty in attracting persons who have these additional qualifications.

Subp. 2. Qualification of case manager; services to an adult. This subpart is necessary to set the standard for qualifications of a case manager providing services to an adult. The qualifications required of a case manager in this subpart are reasonable because they are consistent with Minnesota Statutes,

section 245.462, subdivision 4. Although several members of the advisory committee stated that, in their counties, a case manager would not be hired with less than a Master's Degree, the rule sets forth qualifications consistent with the statutory requirements as set forth in Minnesota Statutes, section 245.462, subdivisions 4 and 17. Furthermore, the Department believes that setting a more rigorous educational requirement would place an undue hardship on counties in greater Minnesota which have more difficulty in attracting persons at the higher educational level.

Subp. 3. Case manager; supervision. This subpart is necessary to clarify which case managers must receive clinical supervision and the frequency of the clinical supervision. Specifying that the person providing clinical supervision of a children's case manager must be qualified as specified in Minnesota Statutes, section 245.4871, subdivision 27 is reasonable to clarify that a case manager who is a mental health practitioner qualified as specified in part 9505.0323, subpart 31 and who is included within the definition of mental health professional in part 9520.0902, subpart 29 is not eligible to provide clinical supervision. See part 9520.0902, subpart 29 and part 9505.0323, subpart 31 which specify the mental health services that certain mental health practitioners may provide.
This subpart is consistent with Minnesota Statutes, section 245.4871, subdivision 4, paragraph (f), in the case of services to children and section 245.462, subdivision 4a, in the case of services to adults, which specify that the required clinical supervision must be documented in the client's record.
Item A is necessary as it clarifies a question often asked by counties. The question is whether clinical supervision is required for a case manager who is qualified as a mental health professional. Minnesota Statutes, section 245.4871, subdivisions 4 and 7 and section 245.462, subdivisions 4 and 4a, require a case manager to have a bachelor's degree and to meet with a mental health professional for clinical supervision. Minnesota Statutes, section 245.4871, subdivision and section 245.462, subdivision 18, require mental health professionals to meet more rigorous qualifications than the minimum case manager qualifications. The Minnesota comprehensive mental health act permits mental health professionals to provide all mental health services without clinical supervision. Therefore, it is reasonable to allow case managers who are qualified as mental health professionals to provide case management services without clinical supervision.
Items B and C are consistent with the requirements of Minnesota Statutes, section 245.4871, subdivision 4 in the case of services to children and under and under section 245.462, subdivision 4 in the case of services to adults.

Subp. 4. Case manager; required training. This subpart is necessary to provide an entry level position for a case manager. The training requirements are reasonable because they are consistent with Minnesota Statutes, section 245.4871, subdivision 4, paragraph (e) in the case of case managers for children and with section 245.462, subdivision 4, in the case of case managers for adults. The Department notes that Minnesota Statutes, section 245.462, subdivision 4 requires the case manager to "complete" 40 hours of training approved by the commissioner and that Minnesota Statutes, section 245.4871, subdivision 4 requires the case manager to "begin" 40 hours of such training. The Department believes it would be unreasonable to set a lower qualification

standard for case managers providing children's services than the one required for services to adults. Therefore, the Department has chosen to require completion of 40 hours of training as a reasonable assurance that all case managers will possess the same minimum level of training.

Subp. 5. Continued training. This subpart is necessary to inform affected persons of the requirement that case managers receive continued training. Continuing training is a requirement placed on many professional persons by their licensing boards or by their professional organizations granting certification. For example, registered nurses are required to obtain 30 contact hours of acceptable continuing education in 24 months (see part 6310.2800, subpart 6); those registered nurses who meet the standards set in Minnesota Statutes, section 245.462, subdivision 18(1) or section 245.4871, subdivision 27 must meet this standard of 30 hours of continuing education in 24 months. Another example relates to licensed social workers. Licensed social workers must fulfill 30 hours of continuing education in each biennial licensure period; the continuing education must "maintain, improve, expand skills and knowledge related to the practice of social work." See part 8740.0110, subpart 7. Under parts 9520.0900 to 9520.0926, certain licensed social workers also may provide case management services.
It is reasonable to require continued training for all case managers because such training offers the case manager the opportunity to keep her or his skills and knowledge up to date, to acquire skills and knowledge in new areas, and thus to be of greater service to clients. The standard of 30 hours of training in a two year period chosen for this subpart is reasonable because it provides flexibility in determining how and when to achieve the training and is consistent with the continuing education requirements set forth for professionals qualified to provide services similar to case management services. Additionally, the continuing training requirement is reasonable as it relates the choice of subject matter to subjects related to the case manager's professional responsibilities toward adults with serious and persistent mental illness and children with severe emotional disturbance and their families and thereby assists the case manager to maintain, improve or expand his or her ability to serve case management clients. Finally specifying that the training must be approved by the case management provider is reasonable as the provider is responsible to see that his or her employees meet the qualification and training standards of this part and further the provider can ensure that the training is tailored to meet the needs of the clients receiving the case management services.

9520.0914 CASE MANAGER'S RESPONSIBILITIES

Subpart 1. **General responsibility.** This subpart sets forth the requirement that a case manager is responsible for providing case management services that assist a client in obtaining certain outcomes. The outcomes for case management services to a child are specified in part 9520.0904; the outcomes for case management services to an adult are in part 9520.0905. This subpart is necessary and reasonable because it informs affected persons of a case manager's responsibility. See the SNR of parts 9520.0904 and 9520.0905 for a discussion of the use of outcomes as rule requirements. This subpart is consistent with Minnesota Statutes, section 245.467, subdivision 1, clause (5) and section 245.4876, subdivision 1, clause (7).

Subp. 2. **Other responsibilities.** This subpart is necessary to set forth the responsibilities of the case manager to carry out certain case management activities.

Item A. The activities required in this item are related to children's case management services.

Subitem (1) is reasonable because Minnesota Statutes, section 245.4881, subdivision 3 (a) requires the case manager to complete the child's functional assessment. It is reasonable to require a written functional assessment because a written document provides evidence and the requirement is consistent with Minnesota Statutes, section 245.4881, subdivision 3, paragraph (a). Minnesota Statutes, section 245.4881, subdivision 3, paragraph (a) requires the case manager to develop an individual family community support plan for a child and subdivision 4 requires the plan to be developed within 30 days of the child's intake for services and to be based on the child's diagnostic assessment and functional assessment. The Department notes that intake as specified in subdivision 4 is the first meeting that occurs beteween the child and the child's case manager after the county has determined the child eligible for case management services. Therefore, the requirements of subitem (1) are consistent with statute. The Department is bound to be consistent with statute.

Subitem (2) requires the case manager to review and update the child's individual community support plan according to the child's needs every 90 days after the first plan is developed. This requirement is consistent with Minnesota Statutes, section 245.4881, subdivision 4.

Minnesota Statutes, section 245.4871, subdivision 3 requires case managers to assess and reassess the delivery, appropriateness, and effectiveness of services over time. A functional assessemnt as defined in Minnesota Statutes, section 245.4871, subdivision 18 means an assessment of the child's mental health needs as presented in the child's diagnostic assessment and the child's functioning in life areas. Therefore, requiring the case manager to review and update the child's functional assessment is reasonable as the functional assessment provides a measure of the appropriateness and effectiveness of the child's services over time.

Subitem (3). This subitem is necessary and reasonable because it restates the requirements in Minnesota Statutes, section 245.4881, subdivisions 3(a) and 4. Subdivisions 3(a) and 4 require the case manager to monitor the delivery of services according to a child's individual family community support plan. Under subdivision 4, the plan has to state the expected outcomes of each service and the criteria for evaluating the effectiveness and appropriateness of the service. Subdivision 4 also requires the case manager to review and revise the plan with the involvement of the child's family, advocates, service providers, and significant others. This subitem is consistent with Minnesota Statutes, section 245.4881, subdivisions 3(a) and 4. It is reasonable to report progress toward outcomes to the child, parent and other members of the case management team on a regular basis because it clarifies the progress towards projected outcomes to all persons involved with the child. See the definition of case management team in part 9520.0902, subpart 5. The progress report also reduces the possibility of misunderstanding between the child, parent, case manager, and other members of the case management team. This subitem also is consistent with Minnesota Statutes, section 245.4871,

subdivision 3 which requires case managers to "assess and reassess the delivery, appropriateness, and effectiveness of services over time." Minnesota Statutes, section 245.4881, subdivision 4(a) requires a review of the plan every 90 days after it is developed.

Subitem (4). This subitem is necessary and reasonable because it informs affected persons about the requirement of Minnesota Statutes, section 245.4871, subdivision 3 that case management services are activities that are coordinated with a child's family community support services. This subitem also is consistent with Minnesota Statutes, section 245.487, subdivision 3, clause 3 (iii), which requires coordinated services. Additionally it is consistent with Minnesota Statutes, section 245.4873, subdivision 4 which states that the case manager is responsible for ongoing coordination with "any other persons responsible for planning, development, and delivery of social services, education, corrections, health, or vocational services for the individual child."

Subitem (5). Case managers must monitor the outcomes of and evaluate the effectiveness and appropriateness of the services provided according to the child's individual family community support plan. See Minnesota Statutes, section 245.4881, subdivisions 3(a) and 4. To monitor as required by statute implies an ongoing responsibility to meet frequently with the child. This subitem is necessary to set a minimum standard for such a meeting. More frequent meetings are not prohibited but may be requested by the child or the child's parent or legal representative. Additionally a need for a more frequent meeting may be stated in the child's individual family community support plan. The minimum standard of every 30 days is reasonable as it considers the case load that may be assigned to a case manager, the time needed to carry out the services specified in the child's individual family community support plan, the time that may have to elapse before the results of the services are observable, and the possibility that the child's mental health status may change. The proposed subitem requires the case manager to "attempt to meet" with the child. The case management service model set forth in parts 9520.0900 to 9520.0926 does not require a client to receive approval from a case manager in order to access mental health services for which the client is otherwise eligible. The case manager is not a gatekeeper controlling access to services. Thus, a client may choose whether and how often to meet with a case manager but a client cannot be compelled to meet with a case manager. Requiring a case manager to attempt to meet with the child is reasonable because it provides a means for the case manager to contact the client at regular intervals and yet does not burden the case manager with a requirement, a meeting, over which the case manager has no control.

Subitem (6) This subitem requires the case manager to meet with the child's parent or legal representative at the parent's or representative's request. This subitem is necessary to assure the case manager will respond to a request from a child's parent or legal representative. It is reasonable because it is consistent with the intent of Minnesota Statutes, section 245.487, clause (7) to include the child's family in planning the child's program of mental health services. Parents and legal representatives of children are responsible for the children's health and safety. They are the primary source of information about their children, including their children's physical and mental health status and daily activities. The parents and legal representatives of

children with severe emotional disturbance who serve on the state mental health advisory council's children subcommittee and those serving on the rule advisory committee also are concerned about their children's programs of mental health services, their children's progress in meeting expected outcomes, and the role that they play in assisting and interacting with their children and the case manager. Parents have an important effect on their children because they are in a position to interact daily and guide their children. Thus it is reasonable to require the case manager to be available to meet at the request of parents and legal representatives because the meeting can provide the parents, the legal representatives, and the case manager an opportunity to exchange information related to the child's status and services.

Subitem (7) This subitem restates a requirement of Minnesota Statutes, section 245.4881, subdivision 3, paragraph (b) that requires the case manager to record in the child's record the services needed by the child that are not available to the child and the child's family and the unmet needs of the child and child's family. The subitem is reasonable because it is consistent with Minnesota Statutes, section 245.4881, subdivision 3, paragraph (b).

Subitem (8) is consistent with Minnesota Statutes 245.4882, subdivision 3 and 245.4883, subdivision 1 (5) which require the residential treatment center or acute care hospital to notify a child's case manager at the time of the child's transition from the facility to the community so that the "case manager can monitor and coordinate the transition and make timely arrangements for the child's appropriate follow-up care in the community.". Additionally the proposed subitem recognizes that although it is good professional practice for a case manager to participate in transition planning and coordinate the services necessary for a smooth transition, circumstances beyond the case manager's control may prevent this participation and coordination. For example, the child's parent or legal representative or, if appropriate, the child may refuse case management services or their refusal to accept some of the services identified as necessary for appropriate follow-up care in the community may prevent the case manager from assuring coordination. Thus, requiring the participation and, to the extent possible, coordination is reasonable as it provides flexibility to meet the circumstances and avoids placing an unreasonable burden on the case manager. This subitem also is consistent with assuring continuity of care as required under Minnesota Statutes, section 245.4871, subdivision 3. See also subitem (9).

Subitem (9) This subitem is necessary to inform affected persons of statutory requirements related to the transition from children's mental health services for adult mental health services. It is reasonable because it is consistent with Minnesota Statutes, section 245.4874, subdivision 10, which requires the county board to assure that children's mental health services are coordinated with adult mental health services. This subitem also is consistent with Minnesota Statutes, section 245.487, subdivision 3, clause (8) which requires mental health services for children when necessary, to "assure a smooth transition from mental health services appropriate for a child to mental health services needed by a person who is at least 18 years of age." It also is consistent the requirement of Minnesota Statutes, section 245.487, subdivision 3, clause (3) of access to a continuum of services. An assessment of the child's potential need for mental health services as an adult involves at least a review and updating of the child's diagnostic

assessment and functional assessment by the child's case management team. The transition to needed adult services may involve locating or choosing a different set of service providers. The period of at least six months before the child's 18th birthday will provide time to accomplish these activities and assure continuity of services if needed.

Subitem (10) This subitem is necessary to inform affected persons of the right to a fair hearing. It is consistent with Minnesota Statutes, sections 245.4887 and 256.045, which establish the right to a fair hearing for a child or a child's family.

Item B. This item is necessary to set forth the responsibilities of the case manager to carry out certain case management activities. The activities in this item are those of an adult's case manager.

Subitem (1). This subitem is reasonable because it is consistent with Minnesota Statutes, section 245.4711, subdivision 3 which requires a case manager to complete a written functional assessment and develop an individual community support plan according to subdivision 4, paragraph (a) of section 245.4711. Subdivision 4, paragraph (a) requires the individual community support plan to be based on a diagnostic assessment and a functional assessment. Subdivision 4, paragraph (a) also requires the case manager to develop the individual community support plan to be developed "within 30 days of client intake." "Client intake", the case of an adult who will receives case management services under parts 9520.0900 to 9520.0926 occurs at the first meeting of the client with the case manager following the determination of the clients eligibility for case management services. Thus, the subitem also is reasonable as it is consistent with Minnesota Statutes, section 245.4711, subdivision 4, paragraph (a).

Subitem (2). This subitem is consistent with the requirement of Minnesota Statutes, section 245.4711, subdivision 4 which requires the case manager to review the adult's individual community support plan every 90 days after it is developed. Requiring the case manager to update the plan at that review according to the adult's needs is consistent with the purpose of the review. As stated in subdivision 4, paragraph (a) and also in Minnesota Statutes, section 245.462, subdivision 12, the adult's individual community support plan must be based, in part, on a functional assessment of the adult. Thus requiring a review of the adult's functional assessment together with the review of the adult's individual community support plan is reasonable as it is consistent with Minnesota Statutes, section 245.4711, subdivision 4.

Subitem (3). This subitem is reasonable because it is consistent with the requirement of monitoring the delivery of services specified in Minnesota Statutes, section 245.462, subdivision 3. Minnesota Statutes, section 245.4711, subdivision 4 requires that, to the extent possible, the adult, the adult's family and service providers must be involved in all phases of development and implementation of the adult's individual community support plan. Developing and implementing an adult's individual community support plan includes monitoring progress toward achieving the specified outcomes, reviewing the plan. The adult, the adult's case manager, and, with the adult's consent, the adult's family and service providers are members of the case management team. It is necessary that information about a client's progress toward the outcomes specified in the adult's individual community support plan be available to the case management team so they will be able to

be involved meaningfully in the review of the adult's individual community support plan. Thus, it is reasonable to require the case manager to report the adult's progress toward achieving these outcomes because the case manager has the responsibility to obtain the information. See Minnesota Statutes, sections 245.462, subdivision 3 and 245.4711, subdivision 4, paragraph (a).

Subitem (4). This subitem is necessary to inform affected persons of the requirement under Minnesota Statutes, section 245.4711, subdivision 4 that the case manager involve the adult with serious and persistent mental illness, the adult's family, advocates, service providers, and other interested persons in all phases of development and implementation of the adult's individual community support plan. This subitem is reasonable because it is consistent with Minnesota Statutes, section 245.4711, subdivision 4.

Subitem (5). A case manager is required under Minnesota Statutes, section 245.4711, subdivision 4 to review an adult's individual community support plan every 90 days after it is developed. It would be unreasonable to expect this review to take place if the case manager had not attempted to meet with the adult. Subdivision 4 also requires the adult's plan to state the frequency of face-to-face contacts. Thus, the subitem is reasonable because it informs both the case manager and the adult of the time interval that would enable the case manager to obtain the adult's participation in reviewing the adult's individual community support plan.

Subitem (6). Minnesota Statutes, section 245.472, subdivision 3, and section 245.474, subdivision 3 require the case manager to monitor and coordinate the transition and arrangements for the client's appropriate follow-up care in the community following the client's discharge from a residential treatment service or regional treatment center. It also is consistent with the requirement of Minnesota Statutes, section 245.473, subdivision 3 that the county board must assure comprehensive planning and continuity of care for persons receiving acute care inpatient hospital services. This subitem is reasonable because it is consistent with the statutes cited in this paragraph. Additionally the proposed subitem recognizes that although it is good professional practice for a case manager to participate in transition planning and coordinate the services necessary for a smooth transition, circumstances beyond the case manager's control may prevent this participation and coordination. For example, the adult may refuse case management services or the adult's refusal to accept some of the services identified as necessary for appropriate follow-up care in the community may prevent the case manager from assuring coordination. Thus, requiring the active participation and, to the extent possible, coordination is reasonable as it provides flexibility to meet the circumstances and avoids placing an unreasonable burden on the case manager.

Subitem (7) is consistent with Minnesota Statutes, section 245.477 which requires that an adult who requests mental health services must be informed of the right to appeal. This subpart is necessary to inform affected persons of this requirement. It is reasonable to require the case manager to inform the client of the right to appeal as the case manager is aware of the requirement and has the responsibility to assist the client in gaining access to needed services.

9520.0916 CASE MANAGEMENT TEAM: CHILD WITH SEVERE EMOTIONAL DISTURBANCE

Subpart 1. Team convened. This subpart authorizes but does not mandate the

case manager to convene a case management team and establishes the frequency with which a team is to meet. This subpart is necessary to clarify the requirement of Minnesota Statutes, section 245.4881, subdivision 4 that, to the extent appropriate, the child, child's family, advocates, service providers and significant others must be involved in all phases of the of development and implementation of the child's individual family community support plan. Bringing together the child, the child's parent or legal representative and the persons who provide the child's services is consistent with Minnesota Statutes, section 245.487, subdivision 3, clause (3) (iii) and section 245.4876, subdivision 1, clause (9). The National Institute of Mental Health, Child and Adolescent Service System Program, (CASSP) recommends a model program of case management services to children with severe emotional disturbance that embodies the concept of a case management team. Under the CASSP model the child's case manager, the child, and the child's parents or legal representative are always members of the team unless their involvement is clinically inappropriate. Stroul and Friedman, op. cit. page vii, in recommending guiding principles for the CASSP model, state that "[t]he families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services. Some members of the advisory committee also held the opinion that parents must always be invited to participate in the planning the child's program of mental health services. However, there are times when a parent's participation will not be required, for example when the child is over age 16, or may impede the team's efforts to assist the child, for example if the parent is hindering or impeding the child's access to services. This subpart recognizes that there are times when it would be inappropriate to include the child's parent or parents. See part 9520.0907. This subpart is consistent with Minnesota Statutes, section 245.487, subdivision 3, clause (7) which states that the commissioner shall "create and ensure a unified, accountable, comprehensive children's mental health system"...that... "includes the child and the child's family in planning the child's program of mental health services, unless clinically inappropriate to the child's needs". The CASSP model also recommends that the services be integrated in a manner that links the child-caring agencies and the agencies' mechanisms for planning, developing and coordinating services. Thus the team also includes representatives of other agencies that provide the services needed by the child. A quarterly meeting is the minimum interval for a holding a team meeting. This interval is coordinated with the schedule for the review and revision of the child's functional assessment and the child's individual family community support plan. These activities are carried out by the case manager with the assistance of the case management team. See part 9520.0908, subpart 2 . Also see part 9505.0914, subpart 2, item A (3) which requires the team to monitor the child's progress. Children make progress at different rates that reflect not only the differences in children's developmental patterns but also factors related to their families and outside activities such as school. Thus the appropriateness of the individual family community support plan and services of some children may require more frequent monitoring, review, and revision than quarterly. Requiring more frequent meetings if needed to monitor the child's progress is reasonable as it relates the meetings to the child's needs and progress and assures an opportunity to monitor the appropriateness of the child's individual family community support plan and services.
The proposed subpart provides that the team may be convened on the manager's

own initiative, upon the request of the child's parent or legal representative or, as appropriate, the child, or at the request of any other member of the team. Thus a request may be made by any member of the team. The members of the team will have different information about the child, the child's functioning and emotional status, and the child's progress toward achieving the outcomes in the child's individual family community support plan. Thus it is reasonable to allow any team member to request a meeting as the meeting provides a way to share this information and monitor the child's progress in achieving the specified outcomes. Persons serving children may include playground workers, the child's classroom teachers, volunteers who assist the child's classroom teachers, representatives of an organization such as Big Brothers or Big Sisters. These persons may or may not be qualified as case managers under part 9520.0912, subpart 1 but each as a team member will have information that will assist a better understanding of the child. Thus this part does not require all members other than the child and child's family or legal representative to be case managers and, in subpart 2 embodies the concept of a team coordinator as recognition that someone who is not qualified as a case manager may be chosen by the child or the child's parent or legal representative. To discern the difference between the model for children and the model for adults, compare this part and its SNR to part 9520.0917 and its SNR, Case managment team for adults with serious and persistent mental illness.

Subpart 2. Team coordinator. This subpart is necessary to clarify who will be the team coordinator and the role of the team coordinator. The National Institute of Mental Health's Child and Adolescent Service System Program recommends that services be child-centered and family-focused. Consistent with this concept is offering the child's parent or the child the opportunity to choose as team coordinator a person other than the case manager assigned by the local agency. It is possible that the child's parent or the child may have established rapport with a representative of another agency, for example a school counselor or social worker, before a child is referred for and determined eligible for case management services. Thus, the opportunity to choose such a person as team coordinator is reasonable as it enables the child's parent or the child to continue and to benefit from an already established relationship. Conversely, the opportunity to choose also is reasonable as it enables the establishment of a new relationship with a person who might have a better understanding of the child's mental health status and needed services. If the team coordinator chosen is not the case manager, requiring the case manager to work with the team coordinator is reasonable because it complies with activities required of a case manager under Minnesota Statutes, section 245.4871,subdivisions 3 and 4.

Subp. 3. Duties of case management team. This subpart is necessary to clarify the duties of a case management team. Requiring the team to clarify and address the roles and responsibilities of the team members is reasonable because it provides information about the expectations and knowledge of the team members and avoids possible misunderstandings and confusion. As stated in Minnesota Statutes, section 245.4881, subdivision 3, a case manager must carry out certain duties including completion of a functional assessment, development of the child's individual family community support plan, reviewing

the child's progress and monitoring the provision of the child's services. See also part 9520.0914, subpart 1 and subpart 2, item A. The case management team includes the case manager and the child, the child's parents, advocates, service providers and significant others. Minnesota Statutes, section 245.4871,subdivision 4 requires that these persons be involved "to the extent appropriate" "in all phases of development and implementation of the individual family community support plan." Thus, the assistance of team members in carrying out these activities is reasonable because it is consistent with the statute. As discussed in the SNR of subpart 2 above, each of these persons may have slightly different information and insights about the child, the child's family, and their needs. Sharing their information enables all the members better to understand the child and the child's needs. Therefore, the assistance is reasonable because the exchange and sharing of information will assist a better understanding of the child and thereby benefit the child.

Minnesota Statutes, section 245.4874 requires a county board to develop "a biennial children's mental health component of the community social services plan required under [Minnesota Statutes] section 256E.09." Further, the county board must submit this plan for the commissioner's approval. Section 245.4874 requires the county board in each county to use its share of mental health and community social services act funds according to this approved biennial plan. Therefore, requiring the recommendation of the case management team about mental health services for the child to be consistent with the services specified in the county's approved plan is reasonable as it assures compliance with the approved plan for services and funding.

9520.0917 CASE MANAGEMENT TEAM; ADULT WITH SERIOUS AND PERSISTENT MENTAL ILLNESS

This part is necessary to establish the concept of a case management team for the provision of case management services to an adult with serious and persistent mental illness. The Department notes that this subpart does not mandate the establishment of a case management team but permits one to be established. If the team is established, it will provide the actual case management services to the adult. The concept of a case management team is consistent with the requirement of Minnesota Statutes, section 245.4711, subdivision 4 which states that " 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 adult's individual community support plan. Furthermore the concept of a team is reasonable as it enables the coordination of the adult's services as required under Minnesota Statutes, section 245.462, subdivision 3 and furthers an exchange and sharing of information that will assist a better understanding of the adult and adult's need for services. However, the adult model differs from the team model proposed in part 9520.0916 as the adult model proposed under part 9520.0917 requires the members of the team other than the adult, the adult's family and advocate to meet at least the qualifications of a case manager under part 9520.0912, subpart 2. This difference is reasonable as it reflects the wider diversity of persons who may provide services to children with severe emotional disturbance as compared to the services provided to an adult. On the other hand persons involved in providing services to the adult come from more structured programs of services such as the community support service program

which must be provided under the clinical supervision of a mental health professional. Such community support services providers are likely to have at least the equivalent of the minimum qualifications of a case manager. See part 9520.0912, subpart 2 about the minimum qualifications of an adult's case manager.
A team commonly has a leader to coordinate the team's activities which include holding meetings, sharing information, developing, monitoring, and implementing plans for the adult. Therefore it is reasonable that one person be designated as team leader because the leader's coordination will assist the team to accomplish its activities in a timely and efficient manner.

9520.0918 DEVELOPMENT OF CHILD'S INDIVIDUAL FAMILY COMMUNITY SUPPORT PLAN.
Subpart 1. Required plan. This subpart is necessary to specify who must develop the child's individual family community support plan, the basis for and time of its development, the frequency of its review, and who must be involved in its development. This subpart is reasonable because it is consistent with Minnesota Statutes,section 245.4881, subdivision 4 and the intent of the Comprehensive Children's Mental Health Act to assure coordination of services. In addition to receiving case management services provided by a county board a child with severe emotional disturbance may receive services from another agency that is part of the local system of care. (See the definition of local system of care in Minnesota Statutes, section 245.4871, subdivision 24.) For example a child may receive case management services and also receive special education services from a local school district. Such a child will have both an individual family community support plan and an individual education plan which specifies the education-related services needed by the child. See part 3525.0200, subpart 6a which defines individual education plan. Some of the same persons are involved in preparing both plans. Thus, it is reasonable to provide flexibility in developing the plans for the child so that the planning process is not unduly burdensome for the child, the child's family, providers or case managers and to maximize the opportunity to coordinate the child's services through the plan development. This flexibility is achievable, for example, by permitting a child's special education plan that incorporates the mental health service components needed by the child to take the place of the child's individual family community support plan. Substituting a service plan developed for the child by another agency for the child's individual family community support plan is one means of assuring a coordinated continuum of services as required under Minnesota Statutes, section 245.487, subdivision 3. Requiring the substituted plan to meet the requirements set for an individual family community support plan under Minnesota Statutes, section 245.4881, subdivision 4 is reasonable because it is consistent with the requirements of this statute.

Subp.2. Review and revision. This subpart is necessary to clarify who must review and revise the child's individual family community support plan, the basis for and frequency of the review, and who must be involved in the review. See Minnesota Statutes, section 245.4881, subdivision 3 which requires the case manager to review the child's progress and monitor the provision of services and also see subdivision 4 which requires the case manager to review the plan every 90 calendar days after it is developed. Requiring the assistance of the child's case management team in reviewing and revising the

plan is reasonable as the requirement assures consistency between this subpart and the duties of the team specified in part 9520.0916 subpart 3. This part also is reasonable as it is consistent with the requirement of 245.4873, subdivision 1 which requires the delivery of mental health services for children in a manner that assures availability and cost effectiveness. Additionally it is reasonable as simplifying access to the child's services is consistent with removing barriers to services as required under Minnesota Statutes, section 245.4873, subdivision 2. Finally, elimination of duplicate services safeguards against unnecessary expenditures and maximizes the availability of limited funds for children eligible for the services. See also part 9520.0904, item E and its SNR which requires coordinated services.

9520.0919 DEVELOPMENT OF ADULT'S INDIVIDUAL COMMUNITY SUPPORT PLAN.
Subpart 1. Required plan. Minnesota Statutes, section 245.4711, subdivision 4 specifies who must develop the adult's individual community support plan, the basis for and time of its development, and who must be involved in its development. This subpart is necessary to inform affected persons about the statutory requirements. In addition to receiving case management services provided by a county board, an adult with serious and persistent mental illness may receive services from another agency that is part of the local delivery system, such as a medical, social, educational, vocation, or other agency providing necessary services. See Minnesota Statutes, section 245.462, subdivision 3. A client who needs one of these services in addition to case management under parts 9520.0900 to 9520.0926 may have a plan of services in addition to an individual community support plan. If the plan of services meet the requirements of an individual community support services plan, substituting it for the individual community support services plan is reasonable because it avoids a duplication of services, promotes coordination of services and is administratively efficient and cost effective.

Subp. 2. Review and revision. This subpart is necessary to inform affected persons of the requirement of Minnesota Statutes, section 245.4711, subdivision 4 that the case manager must review the adult's individual community support plan every 90 days after it is developed. The subpart is reasonable as it is consistent with the statutory requirements. See Minnesota Statutes, section 245.4711, subdivision 4, paragraph (b) which requires the plan to state goals, the activities for accomplishing the goals, and a schedule for each activity. The Department notes that this subpart does not prohibit a review from taking place more frequently than every 90 days. This subpart is reasonable because it recognizes that services to the adult must be based on the adult's current needs. Requiring the plan to focus on the desired changes in the level of the adult's functioning and the desired outcomes of the services is reasonable as it is consistent with Minnesota Statutes, section 245.4711, subdivision 4 which requires the plan to state the coals of each services and the activities for accomplishing each goal. Furthermore it is reasonable to require the plan to specify how the services will be assessed and monitored as such specification informs affected persons and thereby avoids misunderstanding.

9520.0920 CASE MANAGER'S RECORDS RELATED TO SERVICES AND OUTCOME MONITORING.
Subpart 1. Required records; children. This subpart is necessary to inform

affected persons of the recordkeeping requirements about case management services to children set forth in Minnesota Statutes, section 245.4881, subdivision 3, paragraph (b). These requirements include a record of the services needed by the child and the child's family, the services requested by the family, services that are not available, the unmet needs of the child and the child's family, and documentation that the written information required under section 245.4886 has been given to the child and the child's family. The Department notes that the Minnesota Comprehensive Adult Mental Health Act does not set forth similar requirements for records about case management services to adult. Therefore, parts 9520.0900 to 9520.0926 do not mandate all of these records in the case of adults.

Subp. 2. Monitoring and recording outcomes. Under Minnesota Statutes, section 245.4881, subdivision 4 (b)(1), a case manager is responsible to monitor the goals and expected outcomes of each service and evaluate the effectiveness and appropriateness of the service. Minnesota Statutes, section 245.4711, subdivision 4 states that a case manager is responsible for monitoring the delivery of services to an adult with serious and persistent mental illness according to the adult's individual community support plan. The case manager requires systematic information about the client's mental health status and functioning and the client's services and the effect of these services to carry out these responsibilities. Thus, this subpart is necessary to set a standard for records.
The Department notes that this subpart is designed to afford counties flexibility about the documentation of the outcomes. The Department believes that counties have the most information about their circumstances and their clients. The Department also is aware that there are differences among the 87 counties in regard to their present recordkeeping systems. Thus the Department believes it would be unreasonably burdensome to impose a detailed set of recordkeeping requirements on the counties for the purposes of parts 9520.0900 to 9520.0926. At the same time, however, the Department is responsible to "..ensure..an..accountable..mental health services system" and for a system that "provides a quality of service that is effective, efficient, appropriate, and consistent with contemporary standards."
Records of services and their outcomes are necessary to assure accountability and to determine the systems compliance with quality standard. See Minnesota Statutes, section 245.461, subdivision 2 and 245.487, subdivision 3. Thus the Department believes it is reasonable to identify the minimum recordkeeping about outcomes that are necessary to assure accountability and compliance with quality standards. The Department notes that, even though the requirements of items A to E are stated in terms of outcomes, case management service records maintained according to professional standards of good social work practice would show patterns of review of the client's diagnostic assessments, functional assessments, and individual community support or individual family community support plans, evaluation of the client's progress toward achieving outcomes specified in the clients' plans, and access to and coordination of services in a manner that is consistent with continuity of services.
Item A. A desired outcome of case management services is specified in parts 9520.0904 and 9520.0905 as improved or maintained mental health and functioning. Thus, records required under this item are necessary and reasonable to determine whether the case management services were designed to

achieve this goal and to determine the client's progress toward this outcome.
Items B and C. Records required under these items are necessary and reasonable to determine compliance with part 9520.0904, item E in the case of a child and with part 9520.0905, item F in the case of an adult.
Item D. Records required under this item are necessary and reasonable determine compliance with part 9520.0904, item D and with Minnesota Statutes, section 245.487, subdivision 3, clause (8).
Item E. Records required under this item are necessary and reasonable to determine compliance with part 9520.0904, item F and part 9520.0905 item G.

9520.0922 CASE MANAGER'S PROVISION OF OTHER MENTAL HEALTH SERVICES.
This subpart is necessary to describe the case manager's role with respect to the provision of other mental health services to a case management client in addition to the client's case management services. The Department has considered very carefully whether this part as proposed may possibly open the door to a conflict of interest on the part of the case manager who has the responsibility to assure access to services and to provide a continuity of services in a coordinated manner. The Department also has considered very carefully whether this proposed part may act as a barrier to the client's freedom to choose the providers of other mental health services. The Department notes that the Children's subcommittee of the state mental health advisory council passed a resolution opposing the provision of case management services and other mental health services by a case manager to his or her case management service clients. On the other hand, case managers and representatives of counties favored giving case managers the option to provide other needed mental health services to their case management service clients when these services are requested by the adult or the child or the child's parent or legal representative. These persons emphasized that mental health professionals who are not case managers may not be readily available in many greater Minnesota counties and thus these counties may have difficulty in assisting clients to gain access to needed mental health services. Allowing the adult or the child or the child's parent or legal representative to request the client's case manager to provide the client's needed mental health services is reasonable as it assists the client to gain access to the needed mental health services. Additionally limiting the option to a request from the adult or, in the case of a child, the child or the child's parent or legal representative is reasonable as it affords these individuals the opportunity to choose the provider of the needed mental health services. Case managers and other persons serving on the advisory committee also emphasized another benefit to the adult or, in the case of a child, to the child, child's parent or legal representative when the case manager is able to provide both case management and other mental health services needed by the child. An effective case manager builds a feeling of trust and confidence between the client and himself or herself. The client develops confidence in the case manager's ability to be of assistance in accessing services and to work on the client's behalf. The case manager has the information necessary to identify the mental health and other services needed by the client. Enabling the case manager to provide case management and other mental health services to the same client enhances the therapeutic relationship between the case manager and the client. Additionally, enabling the case manager to provide other mental health services reduces the likelihood of duplication and fragmentation of services

that may occur when a client has multiple service providers.
After carefully considering both positions on this issue, the Department believes that the potential benefits to be derived by enabling the clients or, in the case of children, the clients' parents to choose to have the case manager provide other needed mental health services to the client outweigh any potential dangers of conflict of interest and undue influence. Requiring the case manager who provides other mental health services in addition to case management services to meet the minimum qualifications set in statute for the services is reasonable because it ensures consistency with statutes.

9520.0923 COORDINATION OF CASE MANAGEMENT SERVICES WITH OTHER PROGRAMS
A major responsibility of case manager is to coordinate the mental health and other services needed by the client. Some clients needing other services receive case management services in conjunction with the other services. For example, a person who has a diagnosis of mental retardation or a related condition and who also has a diagnosis of severe emotional disturbance will be eligible to receive case management services under parts 9520.0900 to 9520.0926 and under 9525.015 to 9525.0165. This part is necessary to clarify the coordination of case management services provided to such clients. It is reasonable to require the case managers of these systems to coordinate and not duplicate case management services as coordination of services is required under Minnesota Statutes, section 245.487, subdivision 3, clause (3) (iii), and section 245.4871, subdivision 3 in the case of a child and section 245.462, subdivision 3 and 245.467, subdivision 1, clause (7) in the case of adults. At the same time this part is reasonable as it assures duplicate funds will not be used to pay for duplicate services. Eliminating duplication of payment is required under Minnesota Statutes, section 245.4873, subdivision 2, clause (5) in the case of services to children and section 245.461, subdivision 2, clause (6) in the case of services to adults.

9520.0926 APPEALS
This part specifies the right of a client who applies for or receives case management services to appeal a denial, reduction, suspension, or termination of the client's case managment services. This part is necessary to inform affected persons of their right to a fair hearing. It is reasonable because it is consistent with Minnesota Statutes, section 245.4887 in the case of a child and with section 245.477 in the case of an adult. This part continues without substantive change the provisions set forth in subparts 1 to 4 of part 9505.0490 and the emergency amendments thereto.

Expert Witnesses

The Department plans to present Dr. Michael Q, Patton as an outside expert witness. A summary of his credential is attached. Dr. Patton will testify about the use of process and outcomes in program rules, evaluation methodology and research, and the process used to develop the outcomes included in parts 9520.0900 to 9520.0926.

Dated: June 25, 1997

George J. Steffen

for NATALIE HAAS STEFFEN
Commissioner of Human Services