DEPARTMENT OF HUMAN SERVICES

Uniform Service Standards (USS) - Phase I Planning

Contents

Uniform Service Standards project

How to use this document

The following guide is intended to be used with stakeholders when walking through the Phase I proposal for the Uniform Service Standards project. It is meant to show what changes are being made to current law and to explain how proposed statutory language was developed. Sections are shown in the order that they are proposed to be coded in statute. If a topic is discussed in multiple locations in statute, it may not appear as a single section in this document.

Each section begins with the following outline:

- Changes
- Purpose
- Statute or rule language is drawn from
- Review process
- Appendix (if applicable)

It is important to remember that the language presented in this document is not final language. DHS will continue to work with stakeholders to further refine and develop the proposal. Feedback that was recently received by stakeholders has been highlighted in the document.

An updated version of this document will be available to stakeholders the week of January 1, 2019.

We encourage stakeholders to return with proposed changes or identified issues by January 22, 2019.

Items not shown here

DHS staff have worked hard to prepare as much of the proposal for stakeholder review as possible. Some items, including repealers of statute that would be duplicative of the new material, are not fully built. The following sections will be included in the bill but only in reference to standards in 245I where applicable:

- 256B.0622 Assertive Community Treatment and Intensive Residential Treatment Services
- 256B.0623 Adult Rehabilitative Mental Health Services
- 256B.0944 Children's Therapeutic Services and Supports
- 256B.0946 Intensive Treatment in Foster Care
- 256B.0947 Intensive Rehabilitative Mental Health Services

Minn. Stat. 245.462 Adult Mental Health Act – Definitions

Changes:

Definitions within the Adult Mental Health Act are either being deleted or modified. The Adult Mental Health Act will cross-reference the definitions developed and included 256B or 245I. Please note, the definition of "clinical supervision" is being removed and replaced with the term "treatment supervision". This change is being made to clarify the difference between clinical supervision provided to obtain licensure versus the supervision of treatment services.

Purpose:

These changes are being made to ensure that definitions are consistent across all relevant statutes.

Statute or rule this language is drawn from:

The new definitions were created based on the existing Adult Mental Health Act definitions. In some cases, the definitions were modified to improve clarity and based on stakeholder feedback.

Review process:

These definitions were presented to stakeholders in December.

245.462 DEFINITIONS.

Subdivision 1. Definitions.

The definitions in this section apply to sections 245.461 to 245.486.

Subd. 2. Acute care hospital inpatient treatment.

"Acute care hospital inpatient treatment" means short-term medical, nursing, and psychosocial services provided in an acute care hospital licensed under chapter 144.

Subd. 3. Case management services.

"Case management services" means activities that are coordinated with the community support services program as defined in subdivision 6 and are designed to help adults with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. Case management services include developing a functional assessment, an individual community support plan, referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Subd. 4. Case management service provider.

(a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in section 245.4711.

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

(c) Case managers without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 Department of Human Service waiver provision and meet the continuing education and mentoring requirements in this section.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness must receive regular ongoing supervision and clinical supervision totaling 38 hours per year of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The remaining 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services every two years.

(g) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a certified peer specialist under section 256B.0615;

(iii) be a registered nurse without a bachelor's degree;

(iv) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in subdivision 20; or as a child had severe emotional disturbance as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(v) have 6,000 hours work experience as a nondegreed state hospital technician; or

(vi) have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (vi) may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (e), clause (2);

(2) receive at least 40 hours of continuing education in mental illness and mental health services annually; and

(3) receive at least five hours of mentoring per week from a case management mentor.

A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and

may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(i) A case management supervisor must meet the criteria for mental health professionals, as specified in subdivision 18.

(j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of this subdivision are met.

Subd. 4a <u>Treatment Supervision</u>.

<u>Treatment supervision is as defined in 245I.18.</u>

~~**Subd. 4a. Clinical supervision.**~~

~~"Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision must be accomplished by full or part-time employment of or contracts with mental health professionals. Clinical supervision must be documented by the mental health professional cosigning individual treatment plans and by entries in the client's record regarding supervisory activities.~~

Subd. 5. Commissioner.

"Commissioner" means the commissioner of human services.

Subd. 6. Community support services program.

"Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the clinical supervision of a mental health professional designed to help adults with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,
(2) medication monitoring,
(3) assistance in independent living skills,
(4) development of employability and work-related opportunities,
(5) crisis assistance,

(6) psychosocial rehabilitation,
(7) help in applying for government benefits, and
(8) housing support services.

The community support services program must be coordinated with the case management services specified in section 245.4711.

Subd. 7. County board.

"County board" means the county board of commissioners or board established pursuant to the Joint Powers Act, section 471.59, or the Human Services Act, sections 402.01 to 402.10.

Subd. 8. Day treatment services.

"Day treatment," "day treatment services," or "day treatment program" has the meaning given in section256B.0625, subd. X.*(As determined by the Revisor)* ~~in means a structured program of treatment and care provided to an adult in or by: (1) a hospital accredited by the joint commission on accreditation of health organizations and licensed under sections 144.50 to 144.55; (2) a community mental health center under section 245.62; or (3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4712, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least two days a week by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as part of the treatment process. The services are aimed at stabilizing the adult's mental health status, providing mental health services, and developing and improving the adult's independent living and socialization skills. The goal of day treatment is to reduce or relieve mental illness and to enable the adult to live in the community. Day treatment services are not a part of inpatient or residential treatment services. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. The commissioner may limit medical assistance reimbursement for day treatment to 15 hours per week per person.~~

Subd. 9. Diagnostic assessment.

(a) "Diagnostic assessment" has the meaning given in section 256B.XXXX. *(as determined by the Revisor)*~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update.~~

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~
~~(2) description of symptoms, including reason for referral;~~
~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~
~~(5) mental status examination.~~

~~(c) On the basis of the initial components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.~~

Subd. 10. Education and prevention services.

"Education and prevention services" means services designed to educate the general public or special high-risk target populations about mental illness, to increase the understanding and acceptance of problems associated with mental illness, to increase people's awareness of the availability of resources and services, and to improve people's skills in dealing with high-risk situations known to affect people's mental health and functioning. The services include the distribution of information to individuals and agencies identified by the county board and the local mental health advisory council, on predictors and symptoms of mental disorders, where mental health services are available in the county, and how to access the services.

Subd. 11. Emergency services.

"Emergency services" means an immediate response service available on a 24-hour, seven-day-a-week basis for persons having a psychiatric crisis, a mental health crisis, or emergency.

Subd. 11a. Functional assessment.

"Functional assessment" means an assessment by the case manager of the adult's:
(1) mental health symptoms as presented in the adult's diagnostic assessment;
(2) mental health needs as presented in the adult's diagnostic assessment;
(3) use of drugs and alcohol;
(4) vocational and educational functioning;
(5) social functioning, including the use of leisure time;

(6) interpersonal functioning, including relationships with the adult's family;
(7) self-care and independent living capacity;
(8) medical and dental health;
(9) financial assistance needs;
(10) housing and transportation needs; and
(11) other needs and problems.

Subd. 12. Individual community support plan.

"Individual community support plan" means a written plan developed by a case manager on the basis of a diagnostic assessment and functional assessment. The plan identifies specific services needed by an adult with serious and persistent mental illness to develop independence or improved functioning in daily living, health and medication management, social functioning, interpersonal relationships, financial management, housing, transportation, and employment.

Subd. 13. Individual placement agreement.

"Individual placement agreement" means a written agreement or supplement to a service contract entered into between the county board and a service provider on behalf of an individual adult to provide residential treatment services.

Subd. 14. Individual treatment plan.

"Individual treatment plan" has the meaning given in section 256B.XXXX. *(As determined by the Revisor)* ~~means a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness.~~

Subd. 14c. Mental health crisis services.

"Mental health crisis services" means crisis assessment, crisis intervention, and crisis stabilization services.

Subd. 15.

[Repealed, 1991 c 94 s 25]

Subd. 16. Mental health funds.

"Mental health funds" are funds expended under sections 245.73 and 256E.12, federal mental health block grant funds, and funds expended under section 256D.06 to facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0670.

Subd. 17. Mental health practitioner.

(a) "Mental health practitioner" has the meaning given in section 245I.16. ~~means a person providing services to adults with mental illness or children with emotional disturbance who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults.~~

~~(b) For purposes of this subdivision, a practitioner is qualified through relevant coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:~~

~~(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects;~~

~~(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met;~~

~~(3) is working in a day treatment program under section 245.4712, subdivision 2; or~~

~~(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(c) For purposes of this subdivision, a practitioner is qualified through work experience if the person:~~

~~(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, substance use disorder, or emotional disturbance; or~~

~~(ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or~~

~~(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with:~~

~~(i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional at least once a week until the requirement of 4,000 hours of supervised experience is met; or~~

~~(ii) traumatic brain injury or developmental disabilities; completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; and receives clinical supervision as required by applicable statutes~~

~~and rules at least once a week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.~~

~~(d) For purposes of this subdivision, a practitioner is qualified through a graduate student internship if the practitioner is a graduate student in behavioral sciences or related fields and is formally assigned by an accredited college or university to an agency or facility for clinical training.~~

~~(e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's degree if the practitioner:~~

~~(1) holds a master's or other graduate degree in behavioral sciences or related fields; or~~

~~(2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.~~

~~(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical care if the practitioner meets the definition of vendor of medical care in section 256B.02, subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.~~

~~(g) For purposes of medical assistance coverage of diagnostic assessments, explanations of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health practitioner working as a clinical trainee means that the practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of direct practice, treatment team collaboration, continued professional learning, and job management. The practitioner must also:~~

~~(1) comply with requirements for licensure or board certification as a mental health professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or~~

~~(2) be a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.~~

~~(h) For purposes of this subdivision, "behavioral sciences or related fields" has the meaning given in section 256B.0623, subdivision 5, paragraph (d).~~

~~(i) Notwithstanding the licensing requirements established by a health-related licensing board, as defined in section 214.01, subdivision 2, this subdivision supersedes any other statute or rule.~~

Subd. 18. Mental health professional.

"Mental health professional" has the meaning given in section 245I.16. ~~means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways:~~

~~(1) in psychiatric nursing: a registered nurse who is licensed under sections 148.171 to 148.285; and:~~

~~(i) who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; or~~

~~(ii) who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work: a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(3) in psychology: an individual licensed by the Board of Psychology under sections 148.88 to 148.98 who has stated to the Board of Psychology competencies in the diagnosis and treatment of mental illness;~~

~~(4) in psychiatry: a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry, or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy: the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness; or~~

~~(7) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness.~~

Subd. 19. Mental health services.

"Mental health services" means at least all of the treatment services and case management activities that are provided to adults with mental illness and are described in sections 245.461 to 245.486.

Subd. 20. Mental illness.

(a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult has been treated by a crisis team two or more times within the preceding 24 months;

(4) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided;

(5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued;

(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided; or

(7) the adult was eligible as a child under section 245.4871, subdivision 6, and is age 21 or younger.

Subd. 21. Outpatient services.

"Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the clinical supervision of a mental health professional to adults with mental illness who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Subd. 22. Regional treatment center inpatient services.

"Regional treatment center inpatient services" means the 24-hour-a-day comprehensive medical, nursing, or psychosocial services provided in a regional treatment center operated by the state.

Subd. 23. Residential treatment.

"Residential treatment" means a 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for adults with mental illness under Minnesota Rules, parts 9520.0500 to 9520.0670 or other rules adopted by the commissioner.

Subd. 24. Service provider.

"Service provider" means either a county board or an individual or agency including a regional treatment center under contract with the county board that provides adult mental health services funded by sections 245.461 to 245.486.

Subd. 25.

[Repealed, 1989 c 282 art 4 s 64]

Subd. 26. Significant impairment in functioning.

"Significant impairment in functioning" means a condition, including significant suicidal ideation or thoughts of harming self or others, which harmfully affects, recurrently or consistently, a person's activities of daily living in employment, housing, family and social relationships, or education.

Minn. Stat. 245.469 Emergency Services

Changes:

245.469 is being amended.

Purpose:

245.469 authorizes the commissioner and counties to provide emergency mental health services. Revisions to 245.469 are intended to:

1. Align with the Children's Mental Health Act emergency services statute
2. Ensure that Tribes have access to crisis funding
3. Ensure that people requesting crisis services on behalf of someone else receive support.

Statute or rule this language is drawn from:

Minn. Stat. 245.469 and 245.4879. See other requirements in 256B.0624 and 256B.0944.

Review Process:

This language was originally developed in 2016 for the 2017 DHS Policy bill. The 2017 version of the bill also restructured the four different crisis statutes. This language does not restructure the different statutory sections, but does implement some policy reforms. Further structural reorganization, mainly combined adults and children's statute, will occur in Phase II of USS.

245.469 EMERGENCY SERVICES.

Subdivision 1. Availability of emergency services.

By July 1, 1988, county boards must provide or contract for enough emergency services within the county to meet the needs of adults in the county who are experiencing an emotional crisis or mental illness. Clients may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the recipient to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. A tribal authority that accepts crisis grant funding has the same responsibilities within the tribal authority's designated service area. Emergency services must:

(1) promote the safety and emotional stability of adults with mental illness or emotional crises;

(2) minimize further deterioration of adults with mental illness or emotional crises;

(3) help adults with mental illness or emotional crises to obtain ongoing care and treatment; and

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs~~.~~; and

(5) provide support, psychoeducation, and referrals to third parties, including family members, friends, or service providers, for a recipient in need of emergency services.

Subd. 2. Specific requirements.

(a) The county board shall require that all service providers of emergency services to adults with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Subd. 3. Mental health crisis services.

The commissioner of human services shall increase access to mental health crisis services for children and adults. In order to increase access, the commissioner must:

(1) develop a central phone number where calls can be routed to the appropriate crisis services;

(2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving people with traumatic brain injury or intellectual disabilities who are experiencing a mental health crisis;

(3) expand crisis services across the state, including rural areas of the state and examining access per population;

(4) establish and implement state standards for crisis services; and

(5) provide grants to adult mental health initiatives, counties, tribes, or community mental health providers to establish new mental health crisis residential service capacity.

Priority will be given to regions that do not have a mental health crisis residential services program, do not have an inpatient psychiatric unit within the region, do not have an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis residential or intensive residential treatment beds available to meet the needs of the residents in the region. At least 50 percent of the funds must be distributed to programs in rural Minnesota. Grant funds may be used for start-up costs, including but not limited to renovations, furnishings, and staff training. Grant applications shall provide details on how the intended service will address identified needs and shall demonstrate collaboration with crisis teams, other mental health providers, hospitals, and police.

Minn. Stat. 245.696 Additional Duties of Commissioner

Changes:

New language, that contains directions made to the Commissioner regarding peer services. Relocated to the mental health act, to align with how other duties of DHS are constructed.

Purpose:

To continue the responsibility for DHS to select and support a process that certifies peer and family peer specialists.

Statute or rule this language is drawn from:

256B.0615, 256B.0616, as well as changes proposed in the 2017 DHS policy bill.

Review Process:

DHS staff drafted language. Shown to stakeholders in November.

245.696 ADDITIONAL DUTIES OF COMMISSIONER.

Subd. 3.Certification of mental health peer specialists.

The commissioner shall develop a process to certify mental health peer specialists and mental health family peer specialists according to federal guidelines, and section 245I.16 for an entity to bill for reimbursable services. The training and certification curriculum must teach individuals specific skills relevant to providing peer support as appropriate for individual or family peers.

Minn. Stat. 245.4871 Children's Mental Health Act – Definitions

Changes:

Some definitions are being removed from the Children's Mental Health Act. The Children's Mental Health Act will cross-reference the definitions given either in 256B or 245I.

Purpose:

These changes are being made to ensure that definitions are consistent across all relevant statutes. "Crisis assistance" is changing to "crisis planning" distinguish between preparation done in advance of a crisis to identify warning signs and responses as opposed to the urgent services rendered for a crisis that is already occurring.

Statute or rule this language is drawn from:

The new definitions were created based on the existing Children's Mental Health Act definitions. In some cases, the definitions were modified to improve clarity.

Review Process:

These definitions were developed by DHS staff and presented to stakeholders in December. Crisis language was originally part of the 2017 DHS policy bill that did not pass, and shown to stakeholders in 2016.

245.4871 DEFINITIONS.

Subdivision 1. Definitions.

The definitions in this section apply to sections 245.487 to 245.4889.

Subd. 2. Acute care hospital inpatient treatment.

"Acute care hospital inpatient treatment" means short-term medical, nursing, and psychosocial services provided in an acute care hospital licensed under chapter 144.

Subd. 3. Case management services.

"Case management services" means activities that are coordinated with the family community support services and are designed to help the child with severe emotional disturbance and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer services, advocacy, transportation, and legal services. Case management services include assisting in obtaining a comprehensive diagnostic assessment, developing an individual family community support plan, and assisting the child and the child's family in obtaining needed services by coordination with other agencies and assuring continuity of care.

Case managers must assess and reassess the delivery, appropriateness, and effectiveness of services over time.

Subd. 4. Case management service provider.

(a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family.

(b) A case manager must:

(1) have experience and training in working with children;

(2) have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (d);

(3) have experience and training in identifying and assessing a wide range of children's needs;

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families; and

(5) meet the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) A case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) A case manager without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 Department of Human Services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section.

(e) A case manager with at least 2,000 hours of supervised experience in the delivery of mental health services to children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The other 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.

(f) A case manager without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour each week until the requirement of 2,000 hours of experience is met.

(g) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in severe emotional disturbance and mental health services every two years.

(h) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(i) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(j) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a registered nurse without a bachelor's degree;

(iii) have three years of life experience as a primary caregiver to a child with serious emotional disturbance as defined in subdivision 6 within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) have 6,000 hours of supervised work experience in the delivery of mental health services to children with emotional disturbances; hours worked as a mental health behavioral aide I or II under section 256B.0943, subdivision 7, may count toward the 6,000 hours of supervised work experience.

Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements;

(1) have 40 hours of preservice training described under paragraph (f), clause (1);

(2) receive at least 40 hours of continuing education in severe emotional disturbance and mental health service annually; and

(3) receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(l) A case management supervisor must meet the criteria for a mental health professional as specified in subdivision 27.

(m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with severe emotional disturbance of the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Subd. 5. Child.

"Child" means a person under 18 years of age.

Subd. 6. Child with severe emotional disturbance.

For purposes of eligibility for case management and family community support services, "child with severe emotional disturbance" means a child who has an emotional disturbance and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or

(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or

(3) the child has one of the following as determined by a mental health professional:

(i) psychosis or a clinical depression; or

(ii) risk of harming self or others as a result of an emotional disturbance; or

(iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

(4) the child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Subd. 7.

[Repealed, 2014 c 262 art 3 s 18]

Subd. 8. Commissioner.

"Commissioner" means the commissioner of human services.

Subd. 9. County board.

"County board" means the county board of commissioners or board established under the Joint Powers Act, section 471.59, or the Human Services Act, sections 402.01 to 402.10.

Subd. 9a. Crisis planning ~~assistance.~~

"Crisis ~~assistance~~ planning" means the development of a written plan to assist a child's family to contend with a potential crisis and is distinct from the immediate provision of intervention services as defined in section 256B.0944. The plan must address prevention and intervention strategies to be used in a crisis. The plan indentify factors that might precipitate a crisis and behaviors related to the emergence of a crisis, and the resources available to resolve a crisis. ~~assistance to the child, the child's family, and all providers of services to the child to: recognize factors precipitating a mental health crisis, identify behaviors related to the crisis, and be informed of available resources to resolve the crisis. Crisis assistance requires the development of a plan which addresses prevention and intervention strategies to be used in a potential crisis. Other interventions include: (1) arranging for admission to acute care hospital inpatient treatment; (2) crisis placement; (3) community resources for follow-up; and (4) emotional support to the family during crisis. Crisis assistance does not include services designed to secure the safety of a child who is at risk of abuse or neglect or necessary emergency services.~~

Subd. 10. Day treatment services.

"Day treatment," "day treatment services," or "day treatment program" means a structured program of treatment and care provided to a child in:

(1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55;

(2) a community mental health center under section 245.62;

(3) an entity that is under contract with the county board to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475; or

(4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475, that is under contract with an entity that is under contract with a county board.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum two-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services. Day treatment services are not a part of inpatient hospital or residential treatment services.

A day treatment service must be available to a child up to 15 hours a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

Subd. 11.

[Repealed, 2014 c 262 art 3 s 18]

Subd. 11a. Diagnostic assessment.

(a) "Diagnostic assessment" has the meaning given in section 256B.XXXX. *(As determined by the Revisor)* ~~Minnesota Rules, part 9505.0370, subpart 11, and is delivered as provided in Minnesota Rules, part 9505.0372, subpart 1, items A, B, C, and E. Diagnostic assessment includes a standard, extended, or brief diagnostic assessment, or an adult update.~~

~~(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, as provided in Minnesota Rules, part 9505.0371, subpart 5, item C. The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:~~

~~(1) age;~~

~~(2) description of symptoms, including reason for referral;~~

~~(3) history of mental health treatment;~~

~~(4) cultural influences and their impact on the client; and~~

~~(5) mental status examination.~~

~~(c) On the basis of the brief components, the professional or clinical trainee must draw a provisional clinical hypothesis. The clinical hypothesis may be used to address the client's immediate needs or presenting problem.~~

~~(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

Subd. 12. Mental health identification and intervention services.

"Mental health identification and intervention services" means services that are designed to identify children who are at risk of needing or who need mental health services and that arrange for intervention and treatment.

Subd. 13. Education and prevention services.

(a) "Education and prevention services" means services designed to:

(1) educate the general public;

(2) increase the understanding and acceptance of problems associated with emotional disturbances;

(3) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning; and

(4) refer specific children or their families with mental health needs to mental health services.

(b) The services include distribution to individuals and agencies identified by the county board and the local children's mental health advisory council of information on predictors and symptoms of emotional disturbances, where mental health services are available in the county, and how to access the services.

Subd. 14. Emergency services.

"Emergency services" means an immediate response service available on a 24-hour, seven-day-a-week basis for each child having a psychiatric crisis, a mental health crisis, or a mental health emergency.

Subd. 15. Emotional disturbance.

"Emotional disturbance" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is detailed in a diagnostic codes list published by the commissioner; and

(2) seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

"Emotional disturbance" is a generic term and is intended to reflect all categories of disorder described in the clinical code list published by the commissioner as "usually first evident in childhood or adolescence."

Subd. 16. Family.

"Family" means a child and one or more of the following persons whose participation is necessary to accomplish the child's treatment goals: (1) a person related to the child by blood, marriage, or adoption; (2) a person who is the child's foster parent or significant other; (3) a person who is the child's legal representative.

Subd. 17. Family community support services.

"Family community support services" means services provided under the clinical supervision of a mental health professional and designed to help each child with severe emotional disturbance to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with severe emotional disturbance and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with severe emotional disturbance;

(5) assistance with leisure and recreational activities;

(6) crisis assistance, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Subd. 18.

[Repealed, 2014 c 262 art 3 s 18]

Subd. 18a. Functional assessment.

"Functional assessment" means an assessment by the case manager of the child's:

(1) mental health symptoms as presented in the child's diagnostic assessment;

(2) mental health needs as presented in the child's diagnostic assessment;

(3) use of drugs and alcohol;

(4) vocational and educational functioning;

(5) social functioning, including the use of leisure time;

(6) interpersonal functioning, including relationships with the child's family;

(7) self-care and independent living capacity;

(8) medical and dental health;

(9) financial assistance needs;

(10) housing and transportation needs; and

(11) other needs and problems.

Subd. 19. Individual family community support plan.

"Individual family community support plan" means a written plan developed by a case manager in conjunction with the family and the child with severe emotional disturbance on the basis of a diagnostic assessment and a functional assessment. The plan identifies specific services needed by a child and the child's family to:

(1) treat the symptoms and dysfunctions determined in the diagnostic assessment;

(2) relieve conditions leading to emotional disturbance and improve the personal well-being of the child;

(3) improve family functioning;

(4) enhance daily living skills;

(5) improve functioning in education and recreation settings;

(6) improve interpersonal and family relationships;

(7) enhance vocational development; and

(8) assist in obtaining transportation, housing, health services, and employment.

Subd. 20. Individual placement agreement.

"Individual placement agreement" means a written agreement or supplement to a service contract entered into between the county board and a service provider on behalf of a child to provide residential treatment services.

Subd. 21. Individual treatment plan.

"Individual treatment plan" has the meaning given in Minnesota Statutes 256B.XXXX. *(As determined by the Revisor.)* ~~means a written plan of intervention, treatment, and services for a child with an emotional disturbance that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. An individual treatment plan for a child must be developed in conjunction with the family unless clinically inappropriate. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with an emotional disturbance.~~

Subd. 22. Legal representative.

"Legal representative" means a guardian, conservator, or guardian ad litem of a child with an emotional disturbance authorized by the court to make decisions about mental health services for the child.

Subd. 23.

[Repealed, 1991 c 94 s 25]

Subd. 24. Local system of care.

"Local system of care" means services that are locally available to the child and the child's family. The services are mental health, social services, correctional services, education services, health services, and vocational services.

Subd. 24a. Mental health crisis services.

"Mental health crisis services" means crisis assessment, crisis intervention, and crisis stabilization services.

Subd. 25.

[Repealed, 2014 c 262 art 3 s 18]

Subd. 26. Mental health practitioner.

"Mental health practitioner" has the meaning given in section 245I.16.~~245.462, subdivision 17~~.

Subd. 27. Mental health professional.

"Mental health professional" has the meaning given in section 245I.16. ~~means a person providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:~~

~~(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;~~

~~(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;~~

~~(3) in psychology, the mental health professional must be an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;~~

~~(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;~~

~~(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances;~~

~~(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or~~

~~(7) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.~~

Subd. 28. Mental health services.

"Mental health services" means at least all of the treatment services and case management activities that are provided to children with emotional disturbances and are described in sections 245.487 to 245.4889.

Subd. 29. Outpatient services.

"Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the clinical supervision of a mental health professional to children with emotional disturbances who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Subd. 30. Parent.

"Parent" means the birth or adoptive mother or father of a child. This definition does not apply to a person whose parental rights have been terminated in relation to the child.

Subd. 31. Professional home-based family treatment.

"Professional home-based family treatment" means intensive mental health services provided to children because of an emotional disturbance (1) who are at risk of out-of-home placement; (2) who are in out-of-home placement; or (3) who are returning from out-of-home placement. Services are provided to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using information from diagnostic and functional assessments to meet the specific mental health needs of the child and the child's family. Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis assistance, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Subd. 32. Residential treatment.

"Residential treatment" means a 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with emotional disturbances under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted by the commissioner.

Subd. 33. Service provider.

"Service provider" means either a county board or an individual or agency including a regional treatment center under contract with the county board that provides children's mental health services funded under sections 245.487 to 245.4889.

Subd. 33a. Culturally informed mental health consultant.

"Culturally informed mental health consultant" is a person who is recognized by the culture as one who has knowledge of a particular culture and its definition of health and mental health; and who is used as necessary

to assist the county board and its mental health providers in assessing and providing appropriate mental health services for children from that particular cultural, linguistic, or racial heritage and their families.

Subd. 34. Therapeutic support of foster care.

"Therapeutic support of foster care" means the mental health training and mental health support services and clinical supervision provided by a mental health professional to foster families caring for children with severe emotional disturbance to provide a therapeutic family environment and support for the child's improved functioning.

Subd. 35. Transition services.

"Transition services" means mental health services, designed within an outcome oriented process that promotes movement from school to postschool activities, including postsecondary education, vocational training, integrated employment including supported employment, continuing and adult education, adult mental health and social services, other adult services, independent living, or community participation.

Minn. Stat. 245.4879 Emergency Services

Changes:

The Children's Mental Health Act Emergency Services section is being amended.

Purpose:

This language is being added to:

- Ensure alignment with the Adult Mental Health Act Emergency Services section
- Ensure that Tribes have access to crisis funding
- Ensure that people requesting crisis services on behalf of someone else are provided support.

Statute or rule this language is drawn from:

Minn. Stat. 245.469 and 245.4879.

Review process:

This language was originally developed in 2016 for the 2017 DHS Policy. The 2017 version of the bill also restructured the four different crisis statutes. This language does not restructure the different statutory sections, but does implement some policy reforms. Further structural reorganization, mainly combined adults and children's statute, will occur in Phase II of USS.

245.4879 EMERGENCY SERVICES.

Subdivision 1. Availability of emergency services.

County boards must provide or contract for enough mental health emergency services within the county to meet the needs of children, and children's families when clinically appropriate, in the county who are experiencing an emotional crisis or emotional disturbance. The county board shall ensure that parents, providers, and county residents are informed about when and how to access emergency mental health services for children. A child or the child's parent may be required to pay a fee according to section 245.481. Emergency service providers shall not delay the timely provision of emergency service because of delays in determining this fee or because of the unwillingness or inability of the parent to pay the fee. Emergency services must include assessment, crisis intervention, and appropriate case disposition. A tribal authority that accepts crisis grant funding has the same responsibilities within the tribal authority's designated service area. Emergency services must:

(1) promote the safety and emotional stability of children with emotional disturbances or emotional crises;

(2) minimize further deterioration of the child with emotional disturbance or emotional crisis;

(3) help each child with an emotional disturbance or emotional crisis to obtain ongoing care and treatment; ~~and~~

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs~~.~~;

(5) provide support, psychoeducation, and referrals to third parties, including family members, friends, or service providers, for a recipient in need of emergency services.

Subd. 2. Specific requirements.

(a) The county board shall require that all service providers of emergency services to the child with an emotional disturbance provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, a mental health practitioner, or until January 1, 1991, a designated person with training in human services who receives clinical supervision from a mental health professional.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional or mental health practitioner after January 1, 1991, if the county documents that:

(1) mental health professionals or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives clinical supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services reviewed by the state advisory council on mental health and then approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) When emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Chapter 245I

Chapter 245I will establish a new regulatory chapter for outpatient mental health services and Intensive Residential Treatment Providers (IRTS) providers. DHS plans to pursue additional changes in future legislative proposals that will build upon 245I to establish licensure requirements for outpatient mental health services and Intensive Residential Treatment Services (IRTS) providers.

The purpose of creating a new regulatory chapter in Minnesota law for these provider entities and services is to establish a simplified and unified set of regulatory and licensing standards for mental health services providers. By creating a simplified and unified set of regulatory and licensing requirements, providers and people who receive these services should have a better understanding of each service, and how these services work together.

DHS has established a "rapid reaction" group of stakeholders to review proposed statutory language. The rapid reaction stakeholder group is comprised of community mental health providers, for-profit mental health providers, and people receiving services. The rapid reaction stakeholder group was actively engaged in reviewing and offering revisions to the following proposed statutory language. If DHS had additional stakeholder input on individual components it will be specifically identified.

245I.01 Purpose and Citation

Changes:

This is new language.

Purpose:

This language is meant to clearly identify the purpose and scope of 245I. This language also grants the commissioner authority to issue variances.

Note: DHS is pursuing analysis of if additional reference to tribal authority to certify or license a program is required.

Statute or rule this language is drawn from:

Subdivision two adapts language from the statements of purpose and citation of the Adult Mental Health Act and Children's Mental Health Act. Subdivision four adapts language used in 245G, to allow for variances to statute.

Review process:

This language was presented to stakeholders in December.

245I.01 PURPOSE AND CITATION

Subdivision 1. Citation

This chapter may be cited as the "Mental Health Uniform Service Standards Act"

Subd. 2. Purpose

In order to create system of mental health care that is unified, accountable, comprehensive, as provided by 245.461 and 245.487 to promote the recovery of Minnesotans from mental illnesses, it is the policy of the state of Minnesota to support quality outpatient and residential mental health services reimbursable by health insurance programs, including Medical Assistance as well as commercial payers. Further, it is the policy of the state of Minnesota to ensure the safety, rights, and well-being of individuals served in these programs.

Subd. 3. Related law

This chapter must be read in conjunction with covered mental health services listed in 256B.0622, 256B.0623, 256B.0624, 256B.0625, 256B.0943, 256B.0944, 256B.0946, 256B.0947.

Subd. 4. Variances

If the conditions in section 245A.04, subdivision 9, are met, the commissioner may grant variances to the requirements in this chapter that do not affect a client's health or safety.

245I.02 Definitions

Changes:

This new language will establishes definitions for 245I.

Purpose:

These definitions are intended to establish unified, consistent definitions for all mental health services regulated under 245I.

Statute or rule this language is drawn from:

Minn. Stat. 245.462; Minn. Stat. 245.4871, Rule 47

See Appendix A for more information specific to each new definition.

Review Process:

This language was presented to stakeholders in December.

245I. DEFINITIONS

Subdivision 1. Adult

To be developed

Subd. 2. Approval.

"Approval" means the documented review, opportunity to request changes, and agreement with a treatment document by a treatment supervisor or by a client. Approval may be performed by written signature, secure electronic signature or by documented oral approval ~~that is later verified by written signature~~.

Subd. 3 Child

To be developed

Subd. 4. Clinician.

"Clinician" means a mental health professional or clinical trainee who is performing diagnostic assessment, testing, or psychotherapy.

Subd. 5. Commissioner.

"Commissioner" is defined the Commissioner of the Department of Human Services, or their designee.

Subd. 6. Diagnostic Formulation.

"Diagnostic Formulation" means a theoretically-based explanation of the information obtained from a clinical assessment to develop a hypothesis about the cause and nature of the presenting problems and identify a framework for developing the most suitable treatment approach.

Subd. 7. Provider Entity.

"Provider Entity" means the organization, governmental unit, corporation, or other legal body that is enrolled, certified, licensed or otherwise authorized by the Commissioner to provide the services described in this chapter.

Subd. 8. Risk Factors.

To be developed

Subd. 9. Responsivity Factors.

"Responsivity factors" means the factors other than the diagnostic formulation which may modify an individual's treatment needs. This includes learning styles, abilities, cognitive function, cultural background, and personal circumstances. Documentation of responsivity factors includes analysis of how an individual's strengths may be reflected in the planned delivery of services.

Subd. 10. Trauma.

"Trauma" means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes the cumulative emotional or psychological harm of group traumatic experiences, transmitted across generations within a community, often associated with racial and ethnic population groups in the United States who have suffered major intergenerational losses.

Subd. 11. Treatment Supervision.

"Treatment supervision" is defined as the direction and evaluation of individual assessment, treatment planning, and service delivery for each client when services are delivered by an individual who is not a licensed mental health professional or certified rehabilitation specialist. A provider entity shall ensure treatment supervision is delivered and documented according to 245I.18.

Subd. 12. Strengths.

"Strengths" are defined as inner characteristics, virtues and external relationships, activities and connections to resources that contribute to resilience and core competencies and can be built on to insulate individuals and/or communities from harm. *To be revised based on stakeholder feedback.*

Additional definitions to be added:

- *Behavioral sciences and related fields*
- *Mental Health Professional*
- *Certified Mental Health Rehabilitation Practitioner*

245I.10 Training Required.

Changes:

245I.10 will be a new statute, to replace existing pieces of statute in 245 and 256B.

Purpose:

To establish standardized requirements for the training required of staff before starting work with an employer, and requirements for ongoing continuing education. And, to provide for different training needs based on population served.

Statute or rule this language is drawn from:

IRTS variance; Minn. Stat. 256B.0623, subd. 4; 256B.0622, subd. 3a; 256B.0624

See Appendix B for more information specific to each new training required.

Review process:

This language went through multiple rounds of feedback and substantive revision with stakeholders in the summer and fall of 2018.

245I.10 TRAINING REQUIRED.

Subdivision 1.Training plan.

A provider entity must develop a plan to assure that staff receive orientation and ongoing training. The plan must include:

1. A formal process to evaluate the training needs of each staff person, such as through an annual performance evaluation; and
2. A description of how the provider entity determines when additional training of a staff is needed and how and under what time lines the additional training will be provided.

Subd. 2. Documentation of orientation and training.

a. The provider entity must document that orientation and training was provided. All training programs and materials used by the facility must be available for review by regulatory agencies. The documentation must include the following:
    (1) Topic covered in the training;
    (2) Identification of the trainee;
    (3) Names and credentials of the trainer;
    (4) Method of evaluating competency upon completion of training;
    (5) Date(s) of training; and
    (6) Length of training, in hours.
b. Documentation of a continuing education credit accepted by a health licensing board shall be deemed sufficient for this subdivision.

Subd. 3. Orientation.

Orientation must be provided as set forth:

(a) Prior to providing direct contact services, a staff person must receive orientation on the following topics:
   (1) Patient rights as identified in Minnesota Statute 144.651;
   (2) Vulnerable adult and minor maltreatment requirements in Minnesota Statutes, section 245A.65, subdivision 3, and sections 626.557, 626.5572 and 626.556, subdivisions 2,3, and 7;
   (3) Confidentiality, the Minnesota Data Privacy Act, and client privacy;
   (4) Program policies and procedures;
   (5) Professional boundaries;
   (6) Emergency procedures appropriate to the position, including but not limited to fires, inclement weather, missing persons, and medical emergencies;
   (7) Behavior management, crisis intervention and stabilization techniques
   (8) Specific needs of individuals served by the program including but not limited to developmental status, cognitive functioning, physical and mental abilities; and
   (9) Training related to the specific activities and job functions that the staff person will be responsible to carry out, including documentation of the delivery of services.

(b) Orientation to the follow topics must be provided within 90 calendar days of a staff person first providing direct services:
   (1) Trauma informed care;
   (2) Family- and person-centered individual treatment plans, shared decision making and engagement;
   (3) Treatment for co-occurring substance use problems, including the definitions of co-occurring disorders, prevalence of co-occurring disorders, common signs and symptoms of co-occurring disorders, and the etiology of co-occurring disorders;
   (4) Psychotropic medications, side effects and safety around medication management;
   (5) Family systems and building support networks;
   (6) Culturally responsive treatment practices;
   (7) Recovery concepts and principles;
   (8) Person centered planning and positive support strategies; and
   (9) Other training relevant to the staff's role and responsibilities.

c. A provider entity may deem a staff member to have met an orientation requirement in paragraph b by utilizing a staff person's post-secondary education in the previous four years or training experience in the previous two years. The training plan must describe the process and location for verification and documentation of previous training experience.

d. A provider entity may deem a mental health professional to have met a requirement of this subdivision by an evaluation of their competency, including by interview.

Subd. 4. Annual training.

a. A provider entity shall ensure staff who are not licensed mental health professionals to receive fifteen hours of training each year, after the first year of employment.

b. Licensed mental health professional must follow specific training requirements as determined by their specific Board of Licensing.

c. All staff, including licensed mental health professionals must receive annual training on the following topics:
    (1) Vulnerable adult and minor maltreatment requirements in Minnesota Statutes, section 245A.65, subdivision 3, and sections 626.557, 626.5572 and 626.556, subdivisions 2,3, and 7;
    (2) Emergency procedures appropriate to the position, including but not limited to fires, inclement weather, missing persons, and medical emergencies;

d. The selection of additional training topics must be based on program needs and staff competency. Additional training topics may include the following:
    (1) Specific evidence-based and best practices related to the program;
    (2) Family- and person-centered individual treatment plans, shared decision making and engagement;
    (3) Behavior management, crisis intervention and stabilization techniques
    (4) Trauma-informed care;
    (5) Family systems and building support networks;
    (6) Culturally responsive treatment practices;
    (7) Recovery concepts and principles;
    (8) Documentation protocols, including but not limited to functional assessments and progress notes; and
    (9) Transition services, including local community resources.

Subd. 5. Training for Services Provided to Children.

Additional language under development to address training needs of programs serving children.

Note: DHS is also considering potential language to allow a provider to designate a "training year" in which all annual training would be completed, to avoid complexity in tracking when employees started and when training was last performed.

245I.13 Personnel File

Changes:

This is new language.

Purpose:

Establish unified requirements for personnel record retention.

Statute or rule this language is drawn from:

This language was based on language developed for the PRTF variance. Records retention is required under 245A.041 for licensed programs. Other service lines, including ARMHS and CTSS had distinct record keeping requirements.

See Appendix C for more information specific to each new personnel file.

Review process:

This language was developed internally and shown to stakeholders in November.

245I.13. PERSONNEL FILES

For each staff person, a provider entity shall maintain a personnel file that includes:

(1) Verification of the staff person's qualifications including training, education, and licensure;
(2) Documentation required under chapter 245C related to the staff person's background study;
(3) The date of hire;
(4) The effective date of specific duties and responsibilities including the date that the staff person begins direct contact with a client;
(5) Documentation of orientation;
(6) Records of training, license renewal, and educational activities completed during the staff person's employment; and
(7) Records of treatment supervision, if applicable.

245I.16 Provider Qualifications and scope of practice

Changes:
This language consolidates and corrects the various different definitions of staff performing mental health services.

Subd 1. Cross references authority of tribes to qualify staff based on alternative criteria.

Subd. 2 Professional definitions corrected:

- The qualification of nurses defined as permitted to provide mental health services did not align to the Nursing practice regulations.
- Social work corrects the reference to the practice act, 148E, and corrects implication that a LISW or LGSW could practice independently. Social work regulations do not permit this.
- Removed reference to "stated competencies" for Psychology, as obsolete.
- Removed 4,000 hours beyond Master's degree for LPCC and LMFT. Those boards now require this of all candidates.

Subd. 3 Aligns to 2018 revisions led by MACMHP and MHPAM. Some training requirements removed to 245I.10. Clinical trainees described separately.

Subd 5. Clinical Trainees describe separately from practitioners for clarity.

Subd 7. Describes a master's level provider currently authorized by the ARMHS statute as an "allied field." Defined separately, since scope of practice is different from professionals.

Subd 9-12. Describes qualifications for peers and family peers. Requirements directed to the Commissioner are removed to 245.696.

Purpose:
Provide single, accurate definitions of staff qualifications for use in all mental health services. Other definitions will be redirected as cross references to this section.

Statute or rule this language is drawn from:

- Mental Health Behavioral Aides adapted from CTSS (256B.0943)
- Mental Health Rehabilitation Worker, Certified Rehabilitation Specialist adapted from ARMHS (256B.0623)
- Peers and Family Peers adapted from 2017 DHS Policy Bill, 256B.0615, and 256B.0616
- Practitioner adapted from 245.462, as amended in 2018.
- Mental Health Professional and Clinical Trainee written as new language. 245.462, 245.4871, and Rule 47 used as reference.

See Appendix D for more information specific to each new provider qualifications.

Review process:

Health licensing boards were consulted throughout the development of the Professional and Clinical Trainee definitions. DHS developed language, and worked with the Rapid Reaction Group to provide feedback in the summer of 2018. Broadly available to stakeholders in November.

245I.16 PROVIDER QUALIFICATIONS AND SCOPE OF PRACTICE

Subdivision 1. Tribal Providers.

A tribal entity may exercise the provision of section 256B.02, subd. 7, paragraphs b and c, to credential an individual in one of the roles defined by this section.

Subd. 2. Mental health professional qualifications.

(a) The following individuals may provide services as a mental health professional:

(1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental health nursing by a national certification organization, or (ii) nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization;

(2) a licensed independent clinical social worker as defined in section 148E.050, subdivision 5;

(3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

(4) a physician licensed under chapter 147 if the physician is: (i) certified by the American Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

(5) a marriage and family therapist licensed under sections 148B.29 to 148B.39; or

(6) a licensed professional clinical counselor licensed under section 148B.5301.

Subd. 3. Mental health professional scope of practice.

A mental health professional shall maintain a valid license with the mental health professional's governing health-related licensing board and shall only provide services within the scope of practice as determined by the health-related licensing board.

Subd. 4. Mental health practitioner qualifications.

(a) An individual who is qualified in at least one of the ways described in paragraphs (b) to (g) may serve as a mental health practitioner. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults.

(b) An individual is qualified through relevant coursework if the individual completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and:

(1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects;

(2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the individual's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional disturbance, and receives clinical supervision from a mental health professional at least once per week until the requirement of 2,000 hours of supervised experience is met;

(3) is working in a day treatment program under section 245.4712, subdivision 2; or

(4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.

(c) An individual is qualified through work experience if the individual:

(1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or

(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional at least once per week until the requirement of 4,000 hours of supervised experience is met; or (ii) traumatic brain injury or developmental disabilities, completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects, and receives clinical supervision as required by applicable statutes and rules at least once per week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.

(d) An individual is qualified by a bachelor's or master's degree if the individual: (1) holds a master's or other graduate degree in behavioral sciences or related fields; or (2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.

Subd. 5. Mental health practitioner scope of practice.

(a) A mental health practitioner performs services under the treatment supervision of a mental health professional.

(b) A mental health practitioner may perform client education, functional assessments for adult clients, individual treatment plans, level of care assessments, rehabilitative interventions, skills building, and provide direction to a rehabilitation worker or behavioral aid.

(c) A mental health practitioner who is providing services according to 256B.0624 or 256B.0944 may perform crisis assessment and intervention.

Subd. 6. Clinical trainee qualifications.

(a) A clinical trainee is a staff person who is enrolled in or has completed an accredited graduate program of study intended to prepare the individual for independent licensure as a mental health professional and who: (1) participates in a practicum or internship supervised by a mental health professional; or (2) is completing postgraduate hours, according to the requirements of a health-related licensing board.

(b) A clinical trainee is responsible for notifying and applying to a health-related licensing board to ensure the requirements of the health-related licensing board are met. As permitted by a health-related licensing board, treatment oversight under this chapter may be integrated into a plan to meet the supervisory requirements of the health-related licensing board but does not supersede those requirements.

Subd. 7. Clinical trainee scope of practice.

(a) A clinical trainee, under treatment oversight of a mental health professional, may perform psychotherapy, diagnostic assessments, or services that a mental health practitioner may deliver. A clinical trainee shall not provide treatment oversight. A clinical trainee may provide direction to a mental health behavioral aide or mental health rehabilitation worker.

(b) A mental health professional must sign a diagnostic assessment, functional assessment, and treatment plan performed by a clinical trainee before it is valid documentation of services. By signing, a mental health professional assumes responsibility for the quality of services delivered by the clinical trainee.

(c) A clinical trainee shall not deliver services in violation of the practice act of a health-related licensing board, including failure to obtain licensure, if required.

Subd. 8. Certified rehabilitation specialist qualifications.

A certified rehabilitation specialist shall have:

(1) a master's degree from an accredited college or university in behavioral sciences or related fields as defined in section 245I.02, subdivision 2;

(2) at least 4,000 hours of postmaster's supervised experience in the delivery of mental health services; and

(3) a valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.

Subd. 9. Certified rehabilitation specialist scope of practice.

A certified rehabilitation specialist shall provide services based on a client's diagnostic assessment. A certified rehabilitation specialist may provide oversight for mental health certified peer specialists, mental health practitioners, and mental health rehabilitation workers, but is prohibited from performing a diagnostic assessment.

Subd. 10. Mental health certified peer specialist qualifications

A mental health certified peer specialist shall:

(1) Be 21 years of age or older;
(2) Have been diagnosed with a mental illness;
(3) Be a current or former mental health services client; and
(4) Have a valid certification as a mental health certified peer specialist according to section 245.696 subd 3.

Subd. 11. Mental health certified peer specialist scope of practice.

A mental health certified peer specialist shall:

(1) provide peer support that is individualized to the client;

(2) promote recovery goals, self-sufficiency, self-advocacy, and the development of natural supports; and

(3) support the maintenance of skills learned in other services.

Subd. 12. Mental health certified family peer specialist qualifications.

A mental health certified family peer specialist shall:

(1) be 21 years of age or older;

(2) have raised or be currently raising a child with a mental illness;

(3) have experience navigating the children's mental health system; and

(4) have a valid certification as a mental health certified family peer specialist according to section 245.696, subdivision 3.

Subd. 13. Mental health certified family peer specialist scope of practice.

A mental health certified family peer specialist shall provide services to increase the child's ability to function better within the child's home, school, and community. The mental health certified family peer specialist shall:

(1) promote resiliency, self-advocacy, and development of natural supports;
(2) support the maintenance of skills learned in other services;
(3) establish and lead parent support groups;
(4) assist parents to develop coping and problem-solving skills; and
(5) educate parents on community resources.

Subd. 14. Mental health rehabilitation worker qualifications.

(a) A mental health rehabilitation worker shall (1) be 21 years of age or older; (2) have a high school diploma or equivalent; and (3) meet the qualification requirements in paragraph (b).

(b) In addition to the requirements of paragraph (a), a mental health rehabilitation worker shall also:

(1)(i) be fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong;

(ii) during the first 2,000 hours of work, receive monthly documented individual clinical supervision by a mental health professional;

(iii) during the first 160 hours of contact with clients have 18 hours of documented field supervision by a mental health professional or mental health practitioner, and have at least six hours of field supervision quarterly during the following year; and

(iv) during field supervision, have a mental health professional or mental health practitioner review and cosign a client's chart;

(2) have an associate of arts degree;

(3) have two years of full-time postsecondary education or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields;

(4) be a registered nurse;

(5) have within the previous ten years three years of personal life experience with ~~serious~~ mental illness;

(6) have within the previous ten years three years of life experience as a primary caregiver to an adult with a ~~serious~~ mental illness, traumatic brain injury, substance use disorder, or developmental disability; or

(7) have within the previous ten years 2,000 hours of supervised work experience in delivering mental health services to adults with a ~~serious~~ mental illness, traumatic brain injury, substance use disorder, or developmental disability.

(c) If the mental health rehabilitation worker provides crisis residential services, intensive residential treatment services, partial hospitalization, or day treatment services, the mental health rehabilitation worker shall: (1) satisfy paragraph (b), clause (1), items (ii) and (iii); and (2) have 40 hours of additional continuing education on mental health topics during the first year of employment.

Subd. 15. Mental health rehabilitation worker scope of practice.

(a) A mental health rehabilitation worker under supervision of a mental health practitioner or mental health professional may provide rehabilitative mental health services identified in the client's individual treatment plan and individual behavior plan.

(b) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is exempt from the additional qualification requirements in subdivision 11, paragraph(a), clause (3).

Subd. 16. Mental health behavioral aide qualifications.

a. A level 1 mental health behavioral aide shall:

(1) be 18 years of age or older;

(2) have a high school diploma or commissioner of education-selected high school equivalency certification; or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and

(3) meet preservice and continuing education requirements under crisis planning.

b. A level 2 mental health behavioral aide must:

(i) be at least 18 years old; and

(ii) have an associate or bachelor's degree or certificate program established under subdivision 8a.

Subd. 17. Mental health behavioral aide scope of practice.

The mental health behavioral aid under supervision of a mental health professional may provide rehabilitative mental health services identified in the client's individual treatment plan and individual behavior plan.

245I.18 Treatment Supervision

Changes:

Primarily aligns overlapping requirements for supervision. Proposes a requirement for how quickly a mental health professional must be available for consultation, if not already onsite.

Purpose:

Mental health services have previously required "clinical supervision." This is the same term that is used by professional boards of practice to describe the requirements for a clinical trainee. In order to avoid confusion, DHS will instead use the term "treatment supervision" to refer to the supervision provided by a credentialed provider. DHS does not intend to require a specific kind of mental health professional, based on the person supervised.

Statute or rule this language is drawn from:

245I.18, subd. 1 is adapted from Minn. Stat. 256B.0934, subd. 1(b)(2) [CTSS].

245I.18, subd. 2 is based on Minn. R. 9505.0943 (Rule 47), subp. 4(b); Minn. Stat. 256B.0943 [CTSS] and 256B.0623, subd. 6(c) [ARMHS] cross-reference Minn. R. 9505.0934, subp. 4(3).

245I.18, subd. 3 is based on IRTS Variance, R36V.10, subd. 4, and similar requirements in CTSS, Crisis, and ARMHS.

245I.18, subd. 4 is based on Minn. R. 9505.0371, subp. 4(C) [Rule 47]; Minn. Stat. 256B.0943 [CTSS].

245I.18, Subd. 6 is adapted from ARMHS and CTSS.

Review process:

This language was reviewed by the Rapid Reaction Group in October, and more broadly by stakeholders in December.

245I.18 TREATMENT SUPERVISION

Subdivision 1 Generally

(a) A mental health professional shall provide treatment supervision for all staff who are not a mental health professional or certified rehabilitation specialist and are providing services to a client. Treatment supervision shall be based on a staff person's written treatment supervision plan.

(b) Treatment supervision shall focus on the client's treatment needs and the ability of the staff person receiving treatment supervision to provide services, including:

(1) review and evaluation of the interventions delivered;

(2) instruction on alternative strategies when a client is not achieving treatment goals,

(3) review and evaluation of assessments, treatment plans, and progress notes for accuracy and appropriateness;
(4) instruction on the cultural norms or values of the individuals and communities served by the provider entity and how those may impact treatment;
(5) evaluation and feedback on the competencies of direct service staff; and
(6) coaching, teaching, and practicing skills with staff.

(c) A treatment supervisor's responsibility for a supervisee is limited to services provided by the associated provider entity. If a supervisee is employed with multiple provider entities, each entity is responsible for furnishing the necessary treatment supervision.

Subd. 3. Permitted modalities.

(a) Treatment supervision shall be conducted face to face, which includes telemedicine, as defined by 62A.67 to 62A.672.
(b) Treatment supervision may be conducted using individual, small group, or team modalities. Individual oversight means one or more mental health professionals and one staff person receiving treatment supervision. Small group oversight means one or more mental health professionals and two to six staff receiving treatment supervision. Team oversight is defined by the service lines for which it may be used. (*IRTS, ACT, YACT*)

Subd. 4. Immediate Availability for Consultation.

a. A provider entity shall ensure that a mental health professional qualified to provide treatment supervision is immediately available to mental health staff whenever staff are scheduled or available to provide services to a client. This may be met by face to face communication or by telephone, but shall not take more than XX minutes from request to response.
b. A provider entity shall maintain a schedule of the mental health professionals qualified to provide treatment supervision who will be available to staff and a means to reach those mental health professionals. The schedule must be current and readily available to staff.

Subd. 5. Treatment supervision planning.

(a) A written treatment supervision plan shall be developed by a mental health professional who is qualified to provide treatment supervision and the staff person receiving the treatment supervision.
(b) The treatment supervision plan shall include:
(1) the name and qualifications of the staff person receiving treatment supervision;
(2) the name of the provider entity under which the staff person is receiving treatment supervision;
(3) the name and licensure of a mental health professional providing treatment supervision;
(4) the number of hours of individual and group supervision the staff person receiving treatment supervision must complete and the location of this record if it is kept outside of an individual personnel file;
(5) procedures that the staff person receiving treatment supervision shall use to respond to client emergencies; and
(6) authorized scope of practices for the staff person receiving treatment supervision, including:
(i) a description of responsibilities with the provider entity;
(ii) a description of client population; and

(iii)treatment methods and modalities.

(c) The treatment supervision plan shall be completed and implemented within 30 days of a new staff person's employment.

(d) The treatment supervision plan shall be reviewed and updated at least annually.

Subd. 6. Treatment supervision record.

A provider entity shall ensure treatment supervision is documented in the staff person's treatment supervision record. The treatment supervision record shall include:

(1) date and duration of oversight;

(2) identification of oversight type as individual, small group, or team oversight;

(3) name of the mental health professional providing treatment supervision;

(4) subsequent actions that the staff person receiving treatment supervision shall take; and

(5) date and signature of the mental health professional providing treatment supervision.

Subd. 7. Direct observation of mental health rehabilitation workers and behavioral aides.

(a) A mental health practitioner or mental health professional shall directly observe mental health rehabilitation workers while the mental health behavioral aide or mental health rehabilitation worker provides services to clients. The amount of direct observation shall be no less than:

(1) six hours per 40 hours worked during the first 160 hours that the newly hired mental health behavioral aide or mental health rehabilitation worker works; and

(2) six hours during each six months of employment thereafter.

Stakeholders have requested that DHS consider potential alterations or reductions in the requirements of Subd 7 for a Rehabilitation Worker or Behavioral Aide that works in a residential or milieu setting, where regular but intermittent observation is possible.

245I.32 Client File Requirements

Changes:

This is new language.

Purpose:

To standardize requirements for client files across all mental health services.

Statute or rule this language is drawn from:

256B.0623, subd. 11

Review process:

This language has been reviewed the rapid Reaction group in October, and more by stakeholders in November.

245I.32 CLIENT FILE

Subdivision 1. Generally.

A provider entity must maintain a file of current and accurate client records on the premises where the service is provided or coordinated. Entries in each record must be signed and dated by the staff person making the entry.

Subd. 2. Record retention.

A provider entity must retain client records of a discharged client for seven years. A provider entity that ceases to provide treatment service must retain client records for seven years from the date the provider organization stopped providing the service and must notify the commissioner of the location of the client records and the name of the individual responsible for maintaining the client records.

Subd. 3. Contents.

Client files must contain the following, as applicable:

(1) diagnostic assessments;

(2) functional assessments;

(3) individual treatment plans;

(4) individual abuse prevention plans;

(5) crisis plans;

(6) documentation of releases of information;

(7) emergency contacts for the client;

(8) documentation of the date of service, the place of service delivery, signature of the person providing the service, nature, extent and units of service, and place of service delivery;

(9) record of all medication prescribed or administered by staff;

(10) documentation of any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative;

(11) documentation of any contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools;

(12) written information by the client that the client requests be included in the file; and

(13) date and reason the provider entity's services are discontinued.

245I.33 Documentation Standards

Changes:

This is new language

Purpose:

This section aims to clarify the documentation standards that apply to MA payments to providers of services **regulated under 245I.**

Statute or rule this language is drawn from:

Documentation standards

Minn. Stat. 256B.0946, subd. 4(i) [IFTC]

IRTS Variance, R36V.05, subd. 2

Progress notes

Minn. R. 9505.0371, subp. 8(A)(1) [Rule 47]

256B.0943, subd. 11(b) [CTSS]

256B.0623, subd. 11(8) [ARMHS]

ARMHS provider manual

Review process:

This language was reviewed by stakeholders in December.

245I.33 DOCUMENTATION STANDARDS

Subdivision 1. Generally.

As a condition of payment, a provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197, and adhere to documentation standards according to this section. MA payments for a service not documented in a recipient file in accordance with the standards set forth in Minn. R. 9505.2175 and 9505.2197 shall be recovered by the department.

Subd. 2. Documentation standards.

A provider entity must ensure that all documentation required under this chapter:

(1) is typed or legible if handwritten;

(2) identifies the recipient or staff person on each page, as applicable;

(3) is signed and dated by the staff person who completes the documentation, including the staff person's credentials; and
(4) is co-signed and dated by the staff person providing treatment supervision as required under this chapter, including the staff person's credentials.

Subd. 3. Progress notes.

A license holder shall use a progress note to promptly document each occurrence of a mental health service provided to a recipient. A progress note must include the following:

(1) type of service;
(2) date of service including the start and stop time;
(3) location of service;
(4) scope of service, including the:
    (i) goal and objective targeted;
    (ii) intervention delivered and methods used;
    (iii) recipient's response or reaction to intervention;
    (iv) plan for next session; and
    (v) service modality;
(5) signature and printed name and credentials of the staff person who provided the service;
(6) mental health provider travel documentation requirements under section 256B.0625, if applicable; and
(7) other significant observations such as:
    (i) current risk factors the recipient may be experiencing;
    (ii) emergency interventions;
    (iii) consultations with or referrals to other professionals, family or significant others;
    (iv) summary of effectiveness of treatment, prognosis, or discharge planning;
    (v) test results and medications; or
    (vi) changes in mental or physical symptoms.

Minn. Stat. 256B.0624 Adult Crisis Response Services

Purpose:

To implement policy reforms to Mobile/Residential Crisis services, originally proposed in the 2017 DHS Policy Bill. This bill did not become law for unrelated reasons. The 2017 proposal also include structurally rebuilding the crisis statutes to provide for a single combined adult/children's structure. This work is now targeted for Phase II of Uniform Standards, since there is additional overlap and duplication with other service lines.

Statute or rule this language is drawn from:

This is 256B.0624, shown with strike/add. This language will appear in the final bill in this format.

Areas of statute or rule affected or addressed in this topic:

In addition to those used above, 245.469 also govern adult crisis services. Children's crisis is governed by 245.4879 and 256B.0944. This language creates significantly more alignment between adult and children's standards.

Review Process:

Consultation on the 2017 proposals included multiple meetings with crisis providers, advocates, health plans, and other stakeholders. Language was shared and revised with this group through the summer and fall of 2016. Additional consultation took place through NAMI family support groups, to gain perspective from individuals who had called crisis services on behalf of another adult.

256B.0624 ADULT CRISIS RESPONSE SERVICES COVERED.

Subdivision 1. Scope.

Medical assistance covers adult mental health crisis response services as defined in subdivision 2, paragraphs (c) to (e), subject to federal approval, if provided to a recipient as defined in subdivision 3 and provided by a qualified provider entity as defined in this section and by a qualified individual provider working within the provider's scope of practice and as defined in this subdivision and identified in the recipient's individual crisis treatment plan as defined in subdivision 11 and if determined to be medically necessary.

Subd. 2. Definitions.

For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" is an adult behavioral, emotional, or psychiatric situation which, but for the provision of crisis response services, would likely result in significantly reduced levels of functioning in primary activities of daily living, or in an emergency situation, or in the placement of the recipient in a more

restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" is an adult behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services and is consistent with section 62Q.55.

A mental health crisis or emergency is determined for medical assistance service reimbursement by a physician, a mental health professional, or crisis mental health practitioner with input from the recipient whenever possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation. It includes, when feasible, assessing whether the person might be willing to voluntarily accept treatment, determining whether the person has an advance directive, and obtaining information and history from involved family members or caretakers.

(d) "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning. The services, including screening and treatment plan recommendations, must be culturally and linguistically appropriate.

(1) This service is provided on site by a mobile crisis intervention team outside of an inpatient hospital setting. Mental health mobile crisis intervention services must be available 24 hours a day, seven days a week.

(2) The initial screening must consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(3) The mobile crisis intervention team must be available to meet promptly face-to-face with a person in mental health crisis or emergency in a community setting or hospital emergency room.

(4) The intervention must consist of a mental health crisis assessment and a crisis treatment plan.

(5) The team must be available to individuals who are experiencing a co-occurring substance use disorder, who do not need the level of care provided in a detoxification facility.

(6) The treatment plan must include recommendations for any needed crisis stabilization services for the recipient, including engagement in treatment planning and family psychoeducation.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore the recipient to the recipient's prior functional level. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, or a short-term supervised, licensed residential program. Mental health crisis stabilization does not include partial hospitalization or day treatment. Mental health crisis stabilization services includes family psychoeducation.

(f) "Mental health practitioner" has the meaning given in section 245I.16.

(g) "Mental health professional" has the meaning given in section 245I.16.

(h) "Mental health certified family peer specialist" has the meaning given in section 245I.16

(i) "Mental health certified peer specialist" has the meaning given in section 245I.16.

(j) "Mental health rehabilitation worker" has the meaning given in section 245I.16.

(k) "Clinical trainee" has the meaning given in section 245I.16

Subd. 3. Eligibility.

An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is screened as possibly experiencing a mental health crisis or emergency where a mental health crisis assessment is needed; and

(3) is assessed as experiencing a mental health crisis or emergency, and mental health crisis intervention or crisis intervention and stabilization services are determined to be medically necessary.

Subd. 4. Provider entity standards.

(a) A provider entity is an entity that meets the standards listed in paragraph (c) and:

(1) is a county board operated entity; or

(2) is an Indian health service facility or facility owned and operated by a tribe or a tribal organization operating under United States Code, title 25, section 450f; or

(3) is a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

(b) A provider entity that provides crisis stabilization services in a residential setting under subdivision 7 is not required to meet the requirements of paragraph (a), clauses (1) and (2), but must meet all other requirements of this subdivision.

(c) The adult mental health crisis response services provider entity must have the capacity to meet and carry out the following standards:

(1) has the capacity to recruit, hire, and manage and train mental health professionals, practitioners, and rehabilitation workers;

(2) has adequate administrative ability to ensure availability of services;

(3) is able to ensure adequate preservice and in-service training;

(4) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;

(5) is able to ensure that staff are capable of implementing culturally specific treatment identified in the individual treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;

(6) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient during the service partnership between the recipient and providers;

(7) is able to ensure that mental health professionals and mental health practitioners have the communication tools and procedures to communicate and consult promptly about crisis assessment and

interventions as services occur;

(8) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, and mental health crisis services through regularly scheduled interagency meetings;

(9) is able to ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(10) is able to ensure that services are coordinated with other mental health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the adult. Services must also be coordinated with the recipient's case manager if the adult is receiving case management services;

(11) is able to coordinate services with detoxification or withdrawal management services to ensure a recipient receives care that is responsive to chemical and mental health needs;

(12) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486;

(13) is able to submit information as required by the state;

(14) maintains staff training and personnel files including documentation of staff completion of required training modules;

(15) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction including notifying recipients of the process by which the county or tribe accepts and responds to concerns;

(16) is able to keep records as required by applicable laws;

(17) is able to comply with all applicable laws and statutes;

(18) is an enrolled medical assistance provider; and

(19) develops and maintains written policies and procedures regarding service provision and administration of the provider entity, including safety of staff and recipients in high-risk situations;

(20) is able to respond to a call for crisis services in a designated service area, or according to a written agreement with the local mental health authority for an adjacent area; and

(21) documents protocol used when delivering services by telemedicine, as provided by sections 62A.67 to 62A.672, including responsibilities of the originating site, means to promote recipient safety, timeliness for connection and response, and steps to be taken in the event of lost connection.

Subd. 4a. Alternative provider standards.

If a county demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services according to the standards in subdivision 4, paragraph (c), clause (9), the commissioner may approve a crisis response provider based on an alternative plan proposed by a county or group of counties. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services;

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays; and

(3) comply with standards for emergency mental health services in section 245.469.

Subd. 5. Mobile crisis intervention staff qualifications.

For provision of adult mental health mobile crisis intervention services, a mobile crisis intervention team is comprised of at least two mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6), or a combination of at least one mental health professional and one mental health practitioner as defined in section 245.462, subdivision 17, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.

a. Staff for a mobile crisis intervention team must be qualified to provide services in the following ways:

    1) mental health professional;

    2) mental health practitioner;

    3) clinical trainee

    4) certified family peer specialist; or

    5) certified peer specialist.

b. A mobile crisis intervention team is comprised of at least two members, one of whom must be qualified as a mental health professional. A second member must be qualified as a mental health professional, clinical trainee, or mental health practitioner. Additional staff should be added to reflect the needs of the area served.

c. Mental health crisis assessment and intervention services must be led by a mental health professional, a clinical trainee or mental health practitioner under the supervision of a mental health professional as described in subdivision 9.

d. The team must have ~~at least two people with~~ at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources such as the county social services agency, mental health services, and local law enforcement when necessary.

Subd. 6. Crisis assessment and mobile intervention treatment planning.

a. Prior to initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.462, subdivision 6, and 245.469, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify parties involved, and determine an appropriate response.

b. In conducting the screening, a provider shall:

1) employ evidence-based practices as identified by the commissioner in collaboration with the Commissioner of Health to reduce the risk of the recipient's suicide and self-injurious behavior;

2) work with the recipient to establish a plan and time frame for responding to the crisis, including immediate needs for support by telephone or text message until a face-to-face response can arrive;

3) document significant factors related to the determination of a crisis, including prior calls to the crisis team, recent presentation at an emergency department, known calls to 911 or law enforcement, or the presence of third parties with knowledge of a potential recipient's history or current needs;

4) screen for the needs of a third-party caller, including a recipient who primarily identifies as a family member or a caregiver but also presents signs of a crisis; and

5) provide psychoeducation to third-party callers, including education on the available means for reducing self-harm.

c. A provider entity shall consider the following to indicate a positive screening unless the provider entity documents specific evidence to show why crisis response was clinically inappropriate:

1) the recipient presented in an emergency department or urgent care setting, and the health care team at that location requested crisis services; or

2) a peace officer requested crisis services for a recipient who may be subject to transportation under section 253B.05 for a mental health crisis.

d. Direct contact with the recipient is not required before initiating a crisis assessment or intervention service. A crisis team may gather relevant information from a third party at the scene to establish the need for services and potential safety factors. A crisis assessment is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital setting. A service must be provided promptly and respond to the recipient's location whenever possible, including community or clinical settings. As clinically appropriate, a mobile crisis intervention team must coordinate a response with other health care providers if a recipient requires detoxification, withdrawal management, or medical stabilization services in addition to crisis services.

e. If a crisis exists, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the treatment plan described under paragraph (d), a crisis prevention plan, or a wellness recovery action plan.

f. If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be

on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required in subdivision 9.

g. The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.

h. The team must document which short-term goals have been met and when no further crisis intervention services are required. <u>If after an assessment, a crisis provider entity refers a recipient to an intensive setting, including an emergency department, in-patient hospitalization, or crisis residential treatment, a crisis team member who performed or conferred on the assessment must immediately contact the provider entity and consult with the triage nurse or other staff responsible for intake. The crisis team member must convey key findings or concerns that led to the referral. This consultation shall occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section 144.293, subdivision 5. Any available written documentation, including a crisis treatment plan, must be sent no later than the next business day.</u>

i. If the recipient's crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

j. If the recipient's crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

Subd. 7. Crisis stabilization services.

(a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community. If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2).

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Subd. 8. Adult crisis stabilization staff qualifications.

(a) Adult mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. Individual provider staff must have the following qualifications:

(1) be a mental health professional ~~as defined in section 245.462, subdivision 18, clauses (1) to (6)~~;

(2) be a mental health practitioner ~~as defined in section 245.462, subdivision 17. The mental health practitioner must work under the clinical supervision of a mental health professional~~;

(3) be a certified peer specialist ~~under section 256B.0615. The certified peer specialist must work under the clinical supervision of a mental health professional~~; or

(4) be a mental health rehabilitation worker ~~who meets the criteria in section 256B.0623, subdivision 5, paragraph (a), clause (4); works under the direction of a mental health practitioner as defined in section 245.462, subdivision 17, or under direction of a mental health professional; and works under the clinical supervision of a mental health professional.~~

Note: direction and supervision requirements are embedded in the definitions laid out in 245I.16 and 245I.18.

(b) Mental health practitioners and mental health rehabilitation workers must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 9. Supervision.

Mental health practitioners may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by phone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a mental health practitioner provides on-site service;

(4) the mental health professional must:

(i) review and approve of the tentative crisis assessment and crisis treatment plan;

(ii) document the consultation; and

(iii) sign the crisis assessment and treatment plan within the next business day;

~~(5) if the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the recipient face-to-face on the second day to provide services and update the~~

~~crisis treatment plan; and~~

(6) the on-site observation must be documented in the recipient's record and signed by the mental health professional.

Subd. 10. Recipient file.

Providers of mobile crisis intervention or crisis stabilization services must maintain a file for each recipient containing the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient as to why the recipient would not sign the plan;

(2) signed release forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records which document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff;

(8) any written information by the recipient that the recipient wants in the file; and

(9) an advance directive, if there is one available.

Documentation in the file must comply with all requirements of the commissioner.

Subd. 11. Treatment plan.

The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement;

(4) specific objectives directed toward the achievement of each one of the goals;

(5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur;

(8) clear progress notes on outcome of goals;

(9) a written plan must be completed within 24 hours of beginning services with the recipient; and

(10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.

Subd. 12. Excluded services.

The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) recipient transportation costs may be covered under other medical assistance provisions, but transportation services are not an adult mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide adult mental health crisis response services;

(5) services performed by volunteers;

(6) direct billing of time spent "on call" when not delivering services to a recipient;

(7) provider service time included in case management reimbursement. When a provider is eligible to provide more than one type of medical assistance service, the recipient must have a choice of provider for each service, unless otherwise provided for by law;

(8) outreach services to potential recipients; and

(9) a mental health service that is not medically necessary.

Minn. Stat. 256B.625 Neuropsychological assessment.

Changes:

Amends 256B.0625 to add material from Rule 47.

Purpose:

Since Rule 47 is slated for repeal, some services that are covered in 9505.0372 will need to move into statute. Language is shown as "current state" when it is already law in Rule 47, but needs to be added to 256B.0625. DBT contains the only substantive alteration: some requirements currently in Rule 47 will not be brought over, because the national certification DHS has selected as the certification process for providers covers those topics.

Statute or rule this language is drawn from:

9505.0370, Definitions; 9505.0372 Covered Services

Review Process:

Shown to stakeholders in December. Intended to be technical only: preserves current coverage and requirements.

256B.0625 NEUROPSYCHOLOGICAL ASSESSMENT.

256B.0625, Subdivision XX Neuropsychological assessment.

"Neuropsychological assessment" means a specialized clinical assessment of the client's underlying cognitive abilities related to thinking, reasoning, and judgment that is conducted by a qualified neuropsychologist. A neuropsychological assessment must include a face-to-face interview with the client, the interpretation of the test results, and preparation and completion of a report. A client is eligible for a neuropsychological assessment if at least one of the following criteria is met:

A. There is a known or strongly suspected brain disorder based on medical history or neurological evaluation such as a history of significant head trauma, brain tumor, stroke, seizure disorder, multiple sclerosis, neurodegenerative disorders, significant exposure to neurotoxins, central nervous system infections, metabolic or toxic encephalopathy, fetal alcohol syndrome, or congenital malformations of the brain; or

B. In the absence of a medically verified brain disorder based on medical history or neurological evaluation, there are cognitive or behavioral symptoms that suggest that the client has an organic condition that cannot be readily attributed to functional psychopathology, or suspected neuropsychological impairment in addition to functional psychopathology. Examples include:

(1) poor memory or impaired problem solving;

(2) change in mental status evidenced by lethargy, confusion, or disorientation;

(3) deterioration in level of functioning;

(4) marked behavioral or personality change;

(5) in children or adolescents, significant delays in academic skill acquisition or poor attention relative to peers;

(6) in children or adolescents, significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers; and

(7) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands.

C. If neither criterion in item A nor B is fulfilled, neuropsychological evaluation is not indicated.

D. The neuropsychological assessment must be conducted by a neuropsychologist with competence in the area of neuropsychological assessment ~~as stated to the Minnesota Board of Psychology~~ who:

(1) was awarded a diploma by the American Board of Clinical Neuropsychology, the American Board of Professional Neuropsychology, or the American Board of Pediatric Neuropsychology;

(2) earned a doctoral degree in psychology from an accredited university training program:

(a) completed an internship, or its equivalent, in a clinically relevant area of professional psychology;

(b) completed the equivalent of two full-time years of experience and specialized training, at least one which is at the postdoctoral level, in the study and practices of clinical neuropsychology and related neurosciences supervised by a clinical neuropsychologist; and

(c) holds a current license to practice psychology independently in accordance with Minnesota Statutes, sections 148.88 to 148.98;

(3) is licensed or credentialed by another state's board of psychology examiners in the specialty of neuropsychology using requirements equivalent to requirements specified by one of the boards named in ~~sub~~ item (1); or

(4) was approved by the commissioner as an eligible provider of neuropsychological assessment prior to December 31, 2010.

256B.0625, Subdivision XX. Neuropsychological testing.

"Neuropsychological testing" means administering standardized tests and measures designed to evaluate the client's ability to attend to, process, interpret, comprehend, communicate, learn and recall information; and use problem-solving and judgment.

A. Medical assistance covers neuropsychological testing when the client has either:

(1) a significant mental status change that is not a result of a metabolic disorder that has failed to respond to treatment;

(2) in children or adolescents, a significant plateau in expected development of cognitive, social, emotional, or physical function, relative to peers

(3) in children or adolescents, significant inability to develop expected knowledge, skills, or abilities, as required to adapt to new or changing cognitive, social, physical, or emotional demands; or

(4) a significant behavioral change, memory loss, or suspected neuropsychological impairment in addition to functional psychopathology, or other organic brain injury or one of the following:

(a) traumatic brain injury;

(b) stroke;

(c) brain tumor;

(d) substance abuse or dependence;

(e) cerebral anoxic or hypoxic episode;

(f) central nervous system infection or other infectious disease;

(g) neoplasms or vascular injury of the central nervous system;

(h) neurodegenerative disorders;

(i) demyelinating disease;

(j) extrapyramidal disease;

(k) exposure to systemic or intrathecal agents or cranial radiation known to be associated with cerebral dysfunction;

(l) systemic medical conditions known to be associated with cerebral dysfunction, including renal disease, hepatic encephalopathy, cardiac anomaly, sickle cell disease, and related hematologic anomalies, and autoimmune disorders such as lupus, erythematosis, or celiac disease;

(m) congenital genetic or metabolic disorders known to be associated with cerebral dysfunction, such as phenylketonuria, craniofacial syndromes, or congenital hydrocephalus;

(n) severe or prolonged nutrition or malabsorption syndromes; or

(o) a condition presenting in a manner making it difficult for a clinician to distinguish between:

i. the neurocognitive effects of a neurogenic syndrome such as dementia or encephalopathy; and

ii. a major depressive disorder when adequate treatment for major depressive disorder has not resulted in improvement in neurocognitive function, or another disorder such as autism, selective mutism, anxiety disorder, or reactive attachment disorder.

B. Neuropsychological testing must be administered or clinically supervised by a neuropsychologist qualified as defined in ~~subpart 2, item D~~ subdivision XX, paragraph D.

C. Neuropsychological testing is not covered when performed:

(1) primarily for educational purposes;

(2) primarily for vocational counseling or training;

(3) for personnel or employment testing;

(4) as a routine battery of psychological tests given at inpatient admission or continued stay; or

(5) for legal or forensic purposes.

256B.0625, Subdivision XX. Psychological testing.

"Psychological testing" means the use of tests or other psychometric instruments to determine the status of the recipient's mental, intellectual, and emotional functioning. Psychological testing must meet the following requirements:

A. The psychological testing must:

(1) be administered or clinically supervised by a licensed psychologist with competence in the area of psychological testing as stated to the Minnesota Board of Psychology; and

(2) be validated in a face-to-face interview between the client and a licensed psychologist or a mental health practitioner working as a clinical psychology trainee as required by ~~part 9505.0371, subpart 5, item C~~ 245I.16, under the clinical supervision of a licensed psychologist according to ~~part 9505.0371, subpart 5, item A, subitem (2)~~ 254I.16.

B. The administration, scoring, and interpretation of the psychological tests must be done under the clinical supervision of a licensed psychologist when performed by a technician, psychometrist, or psychological assistant or as part of a computer-assisted psychological testing program.

C. The report resulting from the psychological testing must be:

(1) signed by the psychologist conducting the face-to-face interview;

(2) placed in the client's record; and

(3) released to each person authorized by the client.

256B.0625, Subdivision XX. Psychotherapy.

"Psychotherapy" means treatment of a client with mental illness that applies the most appropriate psychological, psychiatric, psychosocial, or interpersonal method that conforms to prevailing community standards of professional practice to meet the mental health needs of the client. Medical assistance covers psychotherapy as conducted by a mental health professional or a ~~mental health practitioner~~ clinical trainee as defined in ~~part 9505.0371, subpart 5, item C~~ 245I.16, as provided in this ~~subpart~~ subdivision.

A. Individual psychotherapy is psychotherapy designed for one client.

B. Family psychotherapy is designed for the client and one or more family members or the client's primary caregiver whose participation is necessary to accomplish the client's treatment goals. Family members or primary caregivers participating in a therapy session do not need to be eligible for medical assistance. For purposes of this subpart, the phrase "whose participation is necessary to accomplish the client's treatment goals" does not include shift or facility staff members at the client's residence. Medical assistance payment for family psychotherapy is limited to face-to-face sessions at which the client is present throughout the family psychotherapy session unless the mental health professional believes the client's absence from the family psychotherapy session is necessary to carry out the client's individual treatment plan. If the client is excluded, the mental health professional must document the reason for and the length of time of the exclusion. The mental health professional must also document the reason or reasons why a member of the client's family is excluded.

C. Group psychotherapy is appropriate for individuals who because of the nature of their emotional, behavioral, or social dysfunctions can derive mutual benefit from treatment in a group setting. For a group of three to eight persons, one mental health professional or ~~practitioner~~ clinical trainee is required to conduct the group. For a group of nine to 12 persons, a team of at least two mental health professionals or two mental health ~~practitioners~~ clinical trainees or one mental health professional and one ~~mental health practitioner~~ clinical trainee is required to co-conduct the group. Medical assistance payment is limited to a group of no more than 12 persons.

D. A multiple-family group psychotherapy session is eligible for medical assistance payment if the psychotherapy session is designed for at least two but not more than five families. Multiple-family group psychotherapy is clearly directed toward meeting the identified treatment needs of each client as indicated in client's treatment plan. If the client is excluded, the mental health professional or ~~practitioner~~ clinical trainee must document the reason for and the length of the time of the exclusion. The mental health professional or ~~practitioner~~ clinical trainee must document the reasons why a member of the client's family is excluded

256B.0625, Subd. 23. Day treatment services.

Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. The commissioner may set

authorization thresholds for day treatment for adults according to subdivision 25. Medical assistance covers day treatment services for children as specified under section 256B.0943. Adult day treatment payment limitations include the following conditions:

Material in this subdivision after this point is copied in from Rule 47. It will be "new" to being in 256B.0625, but is already law.

A. Adult day treatment must consist of at least one hour of group psychotherapy, and must include group time focused on rehabilitative interventions, or other therapeutic services that are provided by a multidisciplinary staff. Adult day treatment is an intensive psychotherapeutic treatment. The services must stabilize the client's mental health status, and develop and improve the client's independent living and socialization skills. The goal of adult day treatment is to reduce or relieve the effects of mental illness so that an individual is able to benefit from a lower level of care and to enable the client to live and function more independently in the community. Day treatment services are not a part of inpatient or residential treatment services.

B. To be eligible for medical assistance payment, a day treatment program must:

(1) be reviewed by and approved by the commissioner;

(2) be provided to a group of clients by a multidisciplinary staff under the clinical supervision of a mental health professional;

(3) be available to the client at least two days a week for at least three consecutive hours per day. The day treatment may be longer than three hours per day, but medical assistance must not reimburse a provider for more than 15 hours per week;

(4) include group psychotherapy done by a mental health professional, or ~~mental health practitioner qualified according to part 9505.0371, subpart 5, item C~~ clinical trainee, and rehabilitative interventions done by a mental health professional, clinical trainee or mental health practitioner daily;

(5) be included in the client's individual treatment plan as necessary and appropriate. The individual treatment plan must include attainable, measurable goals as they relate to services and must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged and include an available discharge plan for the client in the treatment plan; and

(6) document the interventions provided and the client's response daily.

C. To be eligible for adult day treatment, a recipient must:

(1) be 18 years of age or older;

(2) not be residing in a nursing facility, hospital, institute of mental disease, or regional treatment center, unless the recipient has an active discharge plan that indicates a move to an independent living arrangement within 180 days;

(3) have a diagnosis of mental illness as determined by a diagnostic assessment;

(4) have the capacity to engage in the rehabilitative nature, the structured setting, and the therapeutic parts of psychotherapy and skills activities of a day treatment program and demonstrate measurable improvements in the recipient's functioning related to the recipient's mental illness that would result from participating in the day treatment program;

(5) have at least three areas of functional impairment as determined by a functional assessment with the domains prescribed by Minnesota Statutes, section 245.462, subdivision 11a;

(6) have a level of care determination that supports the need for the level of intensity and duration of a day treatment program; and

(7) be determined to need day treatment by a mental health professional who must deem the day treatment services medically necessary.

D. The following services are not covered by medical assistance if they are provided by a day treatment program:

(1) a service that is primarily recreation-oriented or that is provided in a setting that is not medically supervised. This includes: sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(2) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(3) consultation with other providers or service agency staff about the care or progress of a client;

(4) prevention or education programs provided to the community;

(5) day treatment for recipients with primary diagnoses of alcohol or other drug abuse;

(6) day treatment provided in the client's home;

(7) psychotherapy for more than two hours daily; and

(8) participation in meal preparation and eating that is not part of a clinical treatment plan to address the client's eating disorder.

256B.0625, Subdivision XX. <u>Partial hospitalization.</u>

"Partial hospitalization" means a provider's time-limited, structured program of psychotherapy and other therapeutic services, as defined in United States Code, title 42, chapter 7, subchapter XVIII, part E, section 1395x, (ff), that is provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization services. Partial hospitalization is a covered service when it is an appropriate alternative to inpatient hospitalization for a client who is experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission as specified in part 9505.0520, subpart 1, and who has the family and community resources necessary and appropriate to support

the client's residence in the community. Partial hospitalization consists of multiple intensive short-term therapeutic services provided by a multidisciplinary staff to treat the client's mental illness.

256B.0625, Subd. 5l .Intensive mental health outpatient treatment.

Medical assistance covers intensive mental health outpatient treatment for dialectical behavioral therapy for adults. The commissioner shall establish:

(1) certification procedures to ensure that providers of these services are qualified; and

(2) treatment protocols including required service components and criteria for admission, continued treatment, and discharge.

Material in this subdivision after this point is copied in from Rule 47. It will be "new" to being in 256B.0625, but is already law.

"Dialectical behavior therapy" means an evidence-based treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program is certified by the commissioner and involves the following service components: individual dialectical behavior therapy, group skills training, telephone coaching, and team consultation meetings.

Minn. Stat. 256B.0944 Children's Mental Health Crisis Response Services

Purpose:

To implement policy reforms to Mobile/Residential Crisis services, originally proposed in the 2017 DHS Policy Bill. This bill did not become law for unrelated reasons. The 2017 proposal also include structurally rebuilding the crisis statutes to provide for a single combined adult/children's structure. This work is now targeted for Phase 2 of Uniform Standards, since there is additional overlap and duplication with other service lines.

Statute or rule language is drawn from:

This is 256B.0624, shown with strike/add. This language will appear in the final bill in this format.

Areas of statute or rule affected or addressed in this topic:

Adult crisis services are also governed by 245.469. Children's crisis is governed by 245.4879 and 256B.0944. This language creates significantly more alignment between adult and children's standards.

Review Process:

Consultation on the 2017 proposals included multiple meetings with crisis providers, advocates, health plans, and other stakeholders. Language was shared and revised with this group through the summer and fall of 2016. Additional consultation took place through NAMI family support groups, to gain perspective from individuals who had called crisis services on behalf of another adult.

256B.0944 CHILDREN'S MENTAL HEALTH CRISIS RESPONSE SERVICES.

Subdivision 1. Definitions.

For purposes of this section, the following terms have the meanings given them.

(a) "Mental health crisis" means a child's behavioral, emotional, or psychiatric situation that, but for the provision of crisis response services to the child, would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting, including, but not limited to, inpatient hospitalization.

(b) "Mental health emergency" means a child's behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services and is consistent with section 62Q.55. A physician, mental health professional, or crisis mental health practitioner determines a mental health crisis or emergency for medical assistance reimbursement with input from the client and the client's family, if possible.

(c) "Mental health crisis assessment" means an immediate face-to-face assessment by a physician, mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests the child may be experiencing a mental health crisis or mental health

emergency situation.

~~(d)~~ "Mental health mobile crisis intervention services" means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency. Mental health mobile crisis services must help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning. ~~Mental health mobile services must be provided on site by a mobile crisis intervention team outside of an emergency room, urgent care, or an inpatient hospital setting.~~ The services including screening and treatment plan recommendations must be culturally and linguistically appropriate.

(e) "Mental health crisis stabilization services" means individualized mental health services provided to a recipient following crisis intervention services that are designed to restore the recipient to the recipient's prior functional level. The individual treatment plan recommending mental health crisis stabilization must be completed by the intervention team or by staff after an inpatient or urgent care visit. Mental health crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, schools, another community setting, or a short-term supervised, licensed residential program if the service is not included in the facility's cost pool or per diem. Mental health crisis stabilization is not reimbursable when provided as part of a partial hospitalization or day treatment program.

(f) "Mental health practitioner" has the meaning given in section 245I.16.

(g)"Mental health professional" has the meaning given in section 245I.16.

(h)"Mental health certified family peer specialist" has the meaning given in section 245I.16

(i) "Clinical trainee" has the meaning given in section 245I.16

Subd. 2. Medical assistance coverage.

Medical assistance covers medically necessary children's mental health crisis response services, subject to federal approval, if provided to an eligible recipient under subdivision 3, by a qualified provider entity under subdivision 4 or a qualified individual provider working within the provider's scope of practice, and identified in the recipient's individual crisis treatment plan under subdivision 8.

Subd. 3. Eligibility. An eligible recipient is an individual who:

(1) is eligible for medical assistance;

(2) is under age 18 or between the ages of 18 and 21;

(3) is screened as possibly experiencing a mental health crisis or mental health emergency where a mental health crisis assessment is needed; and

(4) is assessed as experiencing a mental health crisis or mental health emergency, and mental health mobile crisis intervention or mental health crisis stabilization services are determined to be medically necessary; ~~and~~

~~(5) meets the criteria for emotional disturbance or mental illness.~~

Subd. 4. Provider entity standards.

(a) A crisis intervention and crisis stabilization provider entity must meet the administrative and clinical standards specified in section 256B.0943, subdivisions 5 and 6, meet the standards listed in paragraph (b), and be:

(1) an Indian health service facility or facility owned and operated by a tribe or a tribal organization

operating under ~~Public Law 93-638 as a 638 facility~~ United States Code, title 25, section 450f;

(2) a county board-operated entity; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring.

(b) The children's mental health crisis response services provider entity must:

(1) ensure that mental health crisis assessment and mobile crisis intervention services are available 24 hours a day, seven days a week;

(2) coordinate services with detoxification or withdrawal management services to ensure a recipient receives care that is responsive to chemical and mental health needs;

(3) directly provide the services or, if services are subcontracted, the provider entity must maintain clinical responsibility for services and billing;

(4) ensure that crisis intervention services are provided in a manner consistent with sections 245.487 to 245.4889; ~~and~~

(5) maintain staff training and personnel files, including documentation of staff completion of required training modules;

(6) establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction including notifying recipients of the process by which the county accepts and responds to concerns;

(7) develop and maintain written policies and procedures regarding service provision that include safety of staff and recipients in high-risk situations;

(8) respond to a call for crisis services in a designated service area, or according to a written agreement with the local mental health authority for an adjacent area; and

(9) document protocol used when delivering services by telemedicine, as provided by sections 62A.67 to 62A.672, including responsibilities of the originating site, means to promote recipient safety, timeliness for connection and response, and steps to be taken in the event of lost connection.

Subd. 4a. Alternative provider standards.

If a provider entity demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services 24 hours a day, seven days a week, according to the standards in subdivision 4, paragraph (b), clause (1), the commissioner may approve a crisis response provider based on an alternative plan proposed by a provider entity. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of crisis services; and

(2) provide mobile services outside of the usual nine-to-five office hours and on weekends and holidays.

Subd. 5. Mobile crisis intervention staff qualifications.

~~(a) To provide children's mental health mobile crisis intervention services, a mobile crisis intervention team must include:~~

~~(1) at least two mental health professionals as defined in section 256B.0943, subdivision 1, paragraph (o); or~~

~~(2) a combination of at least one mental health professional and one mental health practitioner as defined in section 245.4871, subdivision 26, with the required mental health crisis training and under the clinical supervision of a mental health professional on the team.~~

e. Staff for a mobile crisis intervention team must be qualified to provide services in the following ways:

1) mental health professional;

2) mental health practitioner;

3) Clinical trainee or

4) mental health certified family peer specialist.

f. A mobile crisis intervention team is comprised of at least two members, one of whom must be qualified as a mental health professional. A second member must be qualified as a mental health professional, clinical trainee, or mental health practitioner. Additional staff should be added to reflect the needs of the area served.

g. Mental health crisis assessment and intervention services must be led by a mental health professional, a clinical trainee or a mental health practitioner under the supervision of a mental health professional as described in subdivision 9.

h. The team must have ~~at least two people with~~ at least one member providing on-site crisis intervention services when needed. Team members must be experienced in mental health assessment, crisis intervention techniques, and clinical decision making under emergency conditions and have knowledge of local services and resources. The team must recommend and coordinate the team's services with appropriate local resources, including the county social services agency, mental health service providers, and local law enforcement, if necessary.

Subd. 6. Initial screening and crisis assessment planning.

a. Before initiating mobile crisis intervention services, a screening of the potential crisis situation must be conducted. The screening may use the resources of crisis assistance and emergency services as defined in sections 245.4871, subdivision 14, and245.4879, subdivisions 1 and 2. The screening must gather information, determine whether a crisis situation exists, identify the parties involved, and determine an appropriate response.

b. In conducting the screening, a provider shall:

1) employ evidence-based practices as identified by the commissioner in collaboration with the Commissioner of Health to reduce the risk of the recipient's suicide and self-injurious behavior;

2) work with the recipient to establish a plan and time frame for responding to the crisis, including immediate needs for support by telephone or text message until a face-to-face response can arrive;

3) document significant factors related to the determination of a crisis, including prior calls to the crisis team, recent presentation at an emergency department, known calls to 911 or law

enforcement, or the presence of third parties with knowledge of a potential recipient's history or current needs;

4) screen for the needs of a third-party caller, including a recipient who primarily identifies as a family member or a caregiver but also presents signs of a crisis; and

5) provide psychoeducation to third-party callers, including education on the available means for reducing self-harm.

c. A provider entity shall consider the following to indicate a positive screening unless the provider entity documents specific evidence to show why crisis response was clinically inappropriate:

1) the recipient presented in an emergency department or urgent care setting, and the health care team at that location requested crisis services; or

2) a peace officer requested crisis services for a recipient who may be subject to transportation under section 253B.05 for a mental health crisis.

d. Direct contact with the recipient is not required before initiating a crisis assessment or intervention service. A crisis team may gather relevant information from a third party at the scene to establish the need for services and potential safety factors. A crisis assessment is provided face-to-face by a mobile crisis intervention team outside of an inpatient hospital setting. A service must be provided promptly and respond to the recipient's location whenever possible, including community or clinical settings. As clinically appropriate, a mobile crisis intervention team must coordinate a response with other health care providers if a recipient requires detoxification, withdrawal management, or medical stabilization services in addition to crisis services.

e. If a crisis exists, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which emergency services are needed and, as time permits, the recipient's current life situation, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, and current functioning.

f. If the crisis assessment determines mobile crisis intervention services are needed, the intervention services must be provided promptly. As the opportunity presents itself during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the assessment, treatment plan, and actions taken and needed. At least one of the team members must be on site providing crisis intervention services. If providing on-site crisis intervention services, a mental health practitioner must seek clinical supervision as required under subdivision 9.

g. The mobile crisis intervention team must develop an initial, brief crisis treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention. The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The crisis treatment plan must be updated as needed to reflect current goals and services. The team must involve the client and the client's family in developing and implementing the plan.

h. The team must document in progress notes which short-term goals have been met and when no further crisis intervention services are required. If after an assessment, a crisis provider entity refers a recipient to an intensive setting, including an emergency department, in-patient hospitalization, or residential treatment, a crisis team member who performed or conferred on the assessment must

immediately contact the provider entity and consult with the triage nurse or other staff responsible for intake. The crisis team member must convey key findings or concerns that led to the referral. This consultation shall occur with the recipient's consent, the recipient's legal guardian's consent, or as allowed by section 144.293, subdivision 5. Any available written documentation, including a crisis treatment plan, must be sent no later than the next business day.

i. If the client's crisis is stabilized, but the client needs a referral for mental health crisis stabilization services or to other services, the team must provide a referral to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager.

Subd. 7. Crisis stabilization services.

Crisis stabilization services must be provided by a mental health professional or a mental health practitioner, ~~as defined in section 245.462, subdivision 17~~, who works under the clinical supervision of a mental health professional and for a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 8;

(2) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community; and

(3) mental health practitioners must have completed at least 30 hours of training in crisis intervention and stabilization during the past two years.

Subd. 8. Treatment plan.

(a) The individual crisis stabilization treatment plan must include, at a minimum:

(1) a list of problems identified in the assessment;

(2) a list of the recipient's strengths and resources;

(3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement of the goals;

(4) specific objectives directed toward the achievement of each goal;

(5) documentation of the participants involved in the service planning;

(6) planned frequency and type of services initiated;

(7) a crisis response action plan if a crisis should occur; and

(8) clear progress notes on the outcome of goals.

(b) The client, if clinically appropriate, must be a participant in the development of the crisis stabilization treatment plan. The client or the client's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the client and the client's legal guardian. The plan should include services arranged, including specific providers where applicable.

(c) A treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. A written plan must be completed within 24

hours of beginning services with the client.

Subd. 9. Supervision.

A mental health practitioner may provide crisis assessment and mobile crisis intervention services if the following clinical supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity, who is an employee or under contract with the provider entity, must be immediately available by telephone or in person for clinical supervision;

(3) the mental health professional is consulted, in person or by telephone, during the first three hours when a mental health practitioner provides on-site service; and

(4) the mental health professional must review and approve the tentative crisis assessment and crisis treatment plan, document the consultation, and sign the crisis assessment and treatment plan within the next business day.

~~(b) If the mobile crisis intervention services continue into a second calendar day, a mental health professional must contact the client face-to-face on the second day to provide services and update the crisis treatment plan. The on-site observation must be documented in the client's record and signed by the mental health professional.~~

Subd. 10. Client record.

The provider must maintain a file for each client that complies with the requirements under section 256B.0943, subdivision 11, and contains the following information:

(1) individual crisis treatment plans signed by the recipient, mental health professional, and mental health practitioner who developed the crisis treatment plan, or if the recipient refused to sign the plan, the date and reason stated by the recipient for not signing the plan;

(2) signed release of information forms;

(3) recipient health information and current medications;

(4) emergency contacts for the recipient;

(5) case records that document the date of service, place of service delivery, signature of the person providing the service, and the nature, extent, and units of service. Direct or telephone contact with the recipient's family or others should be documented;

(6) required clinical supervision by mental health professionals;

(7) summary of the recipient's case reviews by staff; and

(8) any written information by the recipient that the recipient wants in the file.

Subd. 11. Excluded services.

The following services are excluded from reimbursement under this section:

(1) room and board services;

(2) services delivered to a recipient while admitted to an inpatient hospital;

(3) transportation services under children's mental health crisis response service;

(4) services provided and billed by a provider who is not enrolled under medical assistance to provide children's mental health crisis response services;

(5) crisis response services provided by a residential treatment center to clients in their facility;

(6) services performed by volunteers;

(7) direct billing of time spent "on call" when not delivering services to a recipient;

(8) provider service time included in case management reimbursement;

(9) outreach services to potential recipients; and

(10) a mental health service that is not medically necessary.

256B.XXX1 Diagnostic Assessment Coverage Policy

Changes:

This is language is from Rule 47 and the Adult Mental Health Act. It had been modified based on stakeholder feedback and then added to 256B.

Subd. 2 DA will be generally required

Subd. 2 (b) Limit was already moved to three sessions in 2017. See 245.462 and 245.4871. While statement of coverage for crisis already exists in 0624/0944, additional citation is made to avoid a direct conflict within statute.

Subd. 2 (c) Crisis assessment authorizes stabilization. Again, coverage already exists, but citation added to avoid conflict.

Subd. 2 (d) (e) Brief allowed as a renewal document for therapy

Limit on use with interpreter was intended to be removed in 2017.

Subd. 2 (f) Cross reference will have to get fixed once coding is complete.

Purpose:

Establish required timing and elements of a Diagnostic Assessment for MA payment.

Statute or rule this language is drawn from:

This language is primarily based on current Rule 47 (for statements of coverage, 9505.0372 for the Standard DA) and Adult Mental Health Act (245.462 for the Brief DA). Language will be shown as new language in the bill. Language on case conceptualization was developed internally.

Review process:

This language was presented to stakeholders in December. The diagnostic assessment and supporting language have been through several rounds of revisions in discussion with internal and external stakeholders. Substantial feedback on earlier drafts in August 2018 required DHS to significantly redesign our approach.

Subpart 1. Purpose.

~~This part describes the requirements that outpatient mental health services must meet to receive medical assistance reimbursement.~~

Subp. 2. Client eligibility for mental health services.

~~The following requirements apply to mental health services~~:

a. The provider must use a diagnostic or crisis assessment as specified in ~~part 9505.0372~~ insert corrected cross reference to determine a client's eligibility for mental health services ~~under this part~~, except as provided in paragraphs b through d

~~a.~~ b. Prior to completion of a client's initial diagnostic assessment, a client is eligible for:

1. one explanation of findings;
2. one psychological testing; and
3. ~~either one~~ a combination of individual psychotherapy sessions, ~~one~~ family psychotherapy sessions, ~~one~~ group psychotherapy sessions, individual or family psycho-education sessions; not to exceed three sessions and
4. crisis assessment and intervention services provided according to Minnesota Statutes, section 256B.0624 or 256B.0944

~~(2)~~ c. ~~for a client who is not currently receiving mental health services covered by medical assistance,~~ Based on the needs identified in a crisis assessment as specified in Minnesota Statutes, section 256B.0624 or 256B.0944~~, conducted in the past 60 days may be used to allow up to~~ a client may receive

~~b.~~ 1. crisis stabilization services; and
~~c.~~ 2. a combination of individual psychotherapy sessions, family psychotherapy session, or family psychoeducation sessions not to exceed ten sessions ~~of mental health services~~ within a 12-month period

~~B~~. d. Based on the needs identified in a brief diagnostic assessment a client may receive ~~must meet the requirements of part 9505.0372,~~

~~subpart 1, item D, and~~:

(1) ~~may be used to allow up to~~ a combination of individual psychotherapy sessions, family psychotherapy session, or family psychoeducation sessions not to exceed ten sessions ~~of mental health services as specified in part 9505.0372~~ within a 12-month period ~~before a standard or extended diagnostic assessment is required when the client is:~~

~~a)~~ for any new client; or
~~b)~~ for an existing client who ~~has had fewer than ten sessions of psychotherapy in the previous 12 months and~~ is projected to need fewer than ten sessions ~~of psychotherapy~~ in the next 12 months~~, or~~

(2) ~~who only needs~~ medication management~~; and~~

~~(2) may be used for a subsequent annual assessment, if based upon the client's treatment history and the provider's clinical judgment, the client will need ten or fewer sessions of mental health services in the upcoming 12-month period; and~~
~~(3) must not be used for:~~
~~a. a client or client's family who requires a language interpreter to participate in the assessment unless the client meets the requirements of subitem (1), unit (b), or (2); or~~
~~b. more than ten sessions of mental health services in a 12-month period. If, after completion of ten sessions of mental health services, the mental health professional determines the need for~~

~~additional sessions, a standard assessment or extended assessment must be completed.~~

e. If the amount of services or intensity required by the client exceeds the coverage limits stated in this subdivision, a provider shall complete a standard diagnostic assessment.

f. ~~For a child~~, a new standard ~~or extended~~ diagnostic assessment must be completed:

(1) when the client requires services of greater number or intensity than those permitted by paragraphs b through d ~~child does not meet the criteria for a brief diagnostic assessment;~~

(2) at least annually following the initial diagnostic assessment, if:

(a) additional services are needed; and

(b) the ~~child~~ client does not meet criteria for brief assessment;

(3) when the ~~child's~~ client's mental health condition has changed markedly since the child's most recent diagnostic assessment; or

(4) when the ~~child's~~ client's current mental health condition does not meet criteria of the ~~child's~~ client's current diagnosis.

(5) for an existing client, a new standard DA shall include written update of those parts where significant new or changed information exists, and documentation where there has not been significant change, including discussion with the client about changes in their life situation, functioning, presenting problems, and progress made on treatment goals since the last diagnostic was completed."

~~D. For an adult, a new standard diagnostic assessment or extended diagnostic assessment must be completed:~~

~~(1) when the adult does not meet the criteria for a brief diagnostic assessment or an adult diagnostic assessment update;~~

~~(2) at least every three years following the initial diagnostic assessment for an adult who receives mental health services;~~

~~(3) when the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment; or~~

~~(4) when the adult's current mental health condition does not meet criteria of the current diagnosis.~~

~~E. An adult diagnostic assessment update must be completed at least annually unless a new standard or extended diagnostic assessment is performed. An adult diagnostic assessment update must include an update of the most recent standard or extended diagnostic assessment and any recent adult diagnostic assessment updates that have occurred since the last standard or extended diagnostic assessment.~~

DHS will develop language to support a smooth transition from diagnostic assessments performed under previous standards, and those performed under these revisions.

256B.XXX2 Standard and Brief Diagnostic Assessment

Changes:

Changes to standard and brief diagnostic assessment.

Existing text in 9505.0372. As modified, this would be included in statute.

Purpose:

Set requirements for diagnostic assessment both standard and brief.

Statute or rule this language is drawn from:

This language is primarily based on current Rule 47 (for statements of coverage, 9505.0372 for the Standard DA) and Adult Mental Health Act (245.462 for the Brief DA). Language will be shown as new language in the bill. Language on case conceptualization was developed internally.

256B.XXX2 DIAGNOSTIC ASSESSMENT

A. To be eligible for medical assistance payment, a diagnostic assessment must:

1. identify ~~a~~ at least one mental health diagnosis and recommended mental health services, which are the factual basis to develop the recipient's mental health services and treatment plan; or include a finding that the client does not meet the criteria for a mental health disorder.

B. A standard diagnostic assessment must include a face-to-face interview with the client and contain a written evaluation of a client by a mental health professional or ~~practitioner working under clinical supervision as a~~ clinical trainee ~~according to part 9505.0371, subpart 5, item C.~~ The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

a. the client's current life situation, including the client's:
    a) age
    b) current living situation, including ~~household membership and~~ housing status;
    c) basic needs status ~~including economic status~~;
    d) education level and employment status;
    e) significant personal relationships, including the client's evaluation of relationship quality;
    f) strengths and resources, including the extent and quality of social networks;
    g) belief systems;

h) ~~contextual nonpersonal factors contributing to the client's presenting concerns~~;

i) ~~general physical health and relationship to client's culture; and~~

j) current medications; and

k) immediate risks to health and safety.

2. the ~~reason for~~ elements of the assessment, including the client's:
   a) perceptions of the client's condition;
   b) description of symptoms, including reason for referral;
   c) history of mental health treatment, ~~including review of the client's records;~~
   d) important developmental incidents;
   e) maltreatment, trauma, potential brain injuries, or abuse issues;
   f) history of alcohol and drug usage and treatment;
   g) health history and family health history, including physical, chemical, and mental health history; and
   h) cultural influences and their impact on the client;

C. A clinician completing a diagnostic assessment shall use professional judgement in making inquiries about items d through h. If information cannot be obtained without re-traumatizing the client or harming their willingness to engage in treatment, the clinician shall document which topics will require further attention in the course of treatment.

D. The client's mental status examination;

E. ~~the assessment of client's needs based on the~~ information gathered concerning the client's baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, ~~and~~ safety needs, ~~the~~ including client data that is adequate to support ~~the~~ findings ~~on all axes of~~ based on the current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association; and any differential diagnosis.

For a child under the age of 6, a clinician may use the current edition of the DC: 0–5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood instead of the DSM.

F. the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

G. ~~assessment methods and~~ use of standardized ~~assessment tools~~ outcome measurements by the provider as determined and periodically updated by the commissioner

H. ~~the client's clinical summary,~~

(*Note, this definition comes from 9505.0370)*

~~"Clinical summary" means a written description of a clinician's formulation of the cause of the client's mental health symptoms, the client's prognosis, and the likely consequences of the symptoms; how the client meets the criteria for the diagnosis by describing the client's symptoms, the duration of symptoms, and functional impairment; an analysis of the client's other symptoms, strengths, relationships, life situations, cultural influences, and health concerns and their potential interaction with the diagnosis and formulation of the client's mental health condition; and alternative diagnoses that were considered and ruled out~~

A case conceptualization which explains

1. the diagnostic formulation made based on the information gathered through the interview, assessment, available psychological testing, and collateral information,
2. the needs of the client,
3. risk factors,
4. strengths,
5. and responsivity factors;

The diagnostic assessment shall document recommendations, ~~and prioritization of needed mental health, ancillary or other services~~, client and family participation in assessment and service preferences, and referrals to services required by statute or rule; ~~and~~

Brief DA Requirements

(b) A brief diagnostic assessment must include a face-to-face interview with the client and a written evaluation of the client by a mental health professional or a clinical trainee, ~~as provided in Minnesota Rules, part~~ 9505.0371, ~~subpart 5, item C.~~ The professional or clinical trainee must gather initial components of a standard diagnostic assessment, including the client's:

(1) age;

(2) description of symptoms, including reason for referral;

(3) history of mental health treatment;

(4) cultural influences and their impact on the client; and

(5) mental status examination.

(c) On the basis of the initial components, the professional or clinical trainee must draw a provisional diagnostic formulation ~~clinical hypothesis~~. The diagnostic formulation ~~clinical hypothesis~~ may be used to address the client's immediate needs or presenting problem.

(d) Treatment sessions conducted under authorization of a brief assessment may be used to gather additional information necessary to complete a standard diagnostic assessment if coverage limits in Subd XXX1 will be exceeded ~~or an extended diagnostic assessment.~~

~~(e) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (b), prior to completion of a client's initial diagnostic assessment, a client is eligible for psychological testing as part of the diagnostic process.~~

~~(f) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item A, subitem (1), unit (c), prior to completion of a client's initial diagnostic assessment, but in conjunction with the diagnostic assessment process, a client is eligible for up to three individual or family psychotherapy sessions or family psychoeducation sessions or a combination of the above sessions not to exceed three sessions.~~

~~(g) Notwithstanding Minnesota Rules, part 9505.0371, subpart 2, item B, subitem (3), unit (a), a brief diagnostic assessment may be used for a client's family who requires a language interpreter to participate in the assessment.~~

256B.XXXX Individual Treatment Plan (ITP)

Changes:

This is new language, which would replace multiple definitions or requirements for an ITP across different service lines.

Purpose:

To establish uniform requirements for a treatment plan for all services regulated under 245I.

Statute or rule this language is drawn from:

The first subdivision is adapted from 9505.0372.

Otherwise, this language is primarily based on current 256B.0943, subd. 6(b)(2) CTSS. The proposed language requirements for when an individual treatment plan is required for MA payment of mental health services is the same as current law. An individual treatment plan is not required for those services that do require a standard DA prior to service delivery (e.g. first three therapy sessions prior to DA; 10 therapy sessions following a brief DA; psychological testing; medication management; Mobile crisis services authorized by a crisis treatment team)

This language is shown as strike/add for the purposes of analysis and comparison. It will appear as all underline in the final bill.

See *Appendix E* for more information specific to each new treatment plan.

Review process:

This language was presented to stakeholders in December. Feedback on issues related to the renewal of treatment plans has been under discussion since June 2017.

256B.XXXX INDIVIDUAL TREATMENT PLAN

Subd. 1. Generally

~~Except as provided in subpart 2, item A, subitem (1), a~~ medical assistance payment is available only for mental health services provided in accordance with the client's written individual treatment plan (ITP), with the following exceptions:

1) Services that do not require a standard diagnostic assessment prior to service delivery; and
2) Re-engagement of a client as described in paragraph (*cross-reference once numbered)

Subd. 2 **Required Elements**

~~(2) developing~~ an individual treatment plan ~~that~~ must be:

(i) ~~is~~ based on the information in the client's diagnostic assessment and baselines;

(ii) ~~identified~~ identify goals and objectives of treatment, the treatment strategy, schedule for accomplishing treatment goals and measurable objectives, and the individuals responsible for providing treatment services and supports;

(iii) ~~is~~ developed after completion of the client's diagnostic assessment ~~by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports~~ within three visits, unless otherwise specified by a service line;

(iv) for a child recipient, the ITP ~~is~~ must be developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning;

For an adult recipient, the ITP must be developed through a person centered, culturally appropriate planning process, including allowing identified supports to observe or participate in treatment services, assessment, and treatment planning;

(v) ~~is~~ reviewed at least every 90 days unless otherwise specified by the requirements of a service line and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; and

(vi) ~~is~~ if completed by a staff person who is not a mental health professional, the ITP must be ~~signed~~ approved by the ~~clinical~~ treatment supervisor within two business days from the date the ITP is approved by the client;

~~and by~~ be approved by the client, ~~or by~~ the client's parent, or other person authorized by statute to consent to mental health services for the client In the event that approval cannot be obtained, a mental health professional shall make efforts to obtain approval from an authorized person for a period of thirty days following the date the previous ITP expired. A client shall not be denied service in this time period solely on the basis of an incomplete ITP.

~~A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature.~~

Appendix A – Definitions

TERM	DEFINITION	NOTES
ADULT	To be developed	*To be developed*
APPROVAL	"Approval" means the documented review, opportunity to request changes, and agreement with a treatment document by a treatment supervisor or by a client. Approval may be performed by written signature, secure electronic signature or by documented oral approval ~~that is later verified by written signature~~.	*Derived from current language in CTSS statute, Minn. Stat. 256B.0943, subd. 6(a)(2)(vi).*
CHILD	To be developed	
CLINICIAN	"Clinician" means a mental health professional or clinical trainee who is performing diagnostic assessment, testing, or psychotherapy.	
COMMISSIONER	"Commissioner" is defined the Commissioner of the Department of Human Services, or their designee.	
DIAGNOSTIC FORMULATION	"Diagnostic Formulation" means a theoretically-based explanation of the information obtained from a clinical assessment to develop a hypothesis about the cause and nature of the presenting problems and identify a framework for developing the most suitable treatment approach.	
PROVIDER ENTITY	"Provider Entity" means the organization, governmental unit, corporation, or other legal body that is enrolled, certified, licensed or otherwise authorized by the Commissioner to provide the services described in this chapter.	
RISK FACTORS		
RESPONSIVITY FACTORS	"Responsivity factors" means the factors other than the diagnostic formulation which may modify an individual's treatment needs. This includes learning	

TERM	DEFINITION	NOTES
	styles, abilities, cognitive function, cultural background, and personal circumstances. Documentation of responsivity factors includes analysis of how an individual's strengths may be reflected in the planned delivery of services.	
TRAUMA	"Trauma" means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Trauma includes the cumulative emotional or psychological harm of group traumatic experiences, transmitted across generations within a community, often associated with racial and ethnic population groups in the United States who have suffered major intergenerational losses.	*Drawn from SAMHSA working definitions of Trauma and Historical Trauma.*
TREATMENT SUPERVISION	**"**Treatment supervision" is defined as the direction and evaluation of individual assessment, treatment planning, and service delivery for each client when services are delivered by an individual who is not a licensed mental health professional or certified rehabilitation specialist. A provider entity shall ensure treatment supervision is delivered and documented according to 245I.18	*Replaces clinical supervision, as disambiguation from activity required by a board of practice.*
STRENGTHS	"Strengths" are defined as inner characteristics, virtues and external relationships, activities and connections to resources that contribute to resilience and core competencies and can be built on to insulate individuals and/or communities from harm.	*Adapted from SAMHSA language.*

Appendix B – Training Required

Currently under development and will be included in Version II which will be available January 4th.

Appendix C – Personnel File

Currently under development and will be included in Version II which will be available January 4th.

Appendix D – Provider Qualifications

Mental Health Professional

Proposed	Current (Compared to Children's MH Act. Other definitions noted below.)	Notes (This section is still under development, and will have more detail by Jan 3.
(a) The following individuals may provide services as a mental health professional:	"Mental health professional" means a person providing clinical services in the diagnosis and treatment of children's emotional disorders. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:	
(1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental health nursing by a national certification organization, or (ii) nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization;	(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;	Requirements aligned to board/practice act.
(2) a licensed independent clinical social worker as defined in section 148E.050, subdivision 5;	(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;	Scope of practice corrected to align to board. Practice act reference corrected.
(3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;	(3) in psychology, the mental health professional must be an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology	Stated competencies obsolete.

Proposed	Current (Compared to Children's MH Act. Other definitions noted below.)	Notes (This section is still under development, and will have more detail by Jan 3.
	competencies in the diagnosis and treatment of mental disorders;	
(4) a physician licensed under chapter 147 if the physician is: (i) certified by the American Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;	(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry or an osteopathic physician licensed under chapter 147 and certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification in psychiatry;	
(5) a marriage and family therapist licensed under sections 148B.29 to 148B.39;	(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances;	4000 hours post masters now a board requirement.
(6) a licensed professional clinical counselor licensed under section 148B.5301.	(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or	4000 hours post masters now a board requirement.
	(7) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.	This clause is typically omitted in service lines. See definitions below.
A tribal entity may exercise the provision of section 256B.02, subd. 7, paragraphs b and c, to credential an		

Proposed	Current (Compared to Children's MH Act. Other definitions noted below.)	Notes (This section is still under development, and will have more detail by Jan 3.
individual in one of the roles defined by this section.		

Additional Context for Mental Health Professional

The following are the 47 different locations where Mental Health Professional is defined in statute, rule and variance. The first ten are the definitions that are unique, and then cross referenced by the remaining 37.

Statute, Rule, or Variance	Notes on the definition
Rule 47 9505.0371, subp 5.	Outdated on psychology, psychiatry, but does include tribal providers.
Adult MH Act, 245.462 Subd 18.	Confusing language on Nursing, incorrect description of Social Work, omits tribal providers. Includes "Allied Fields"
Children's MH Act 245.4871 Subd 27	Confusing language on Nursing, incorrect description of Social Work, omits tribal providers. Includes "Allied Fields"
62A.152	Refers to MH Acts, (1-5), omitting LPCC
62A.3094	Omits LMFT
Rule 9505.0175	Refers to 245.462 and 245.4871 (1-4). Omits LPCC, LMFT, tribal providers. Bad cross reference to clinical trainees.
256J.08	Combines Adult/Child MH Act definitions (including LISCW error), with omission of Osteopathic Physicians
Rule 9533.0110	Combines Adult/Child MH Act, (fixes LISCW reference, but omits Osteopathic Physicians
256B.0623 Subd 5 (ARMHS)	Refers to 245.462 (1-6), also includes "Allied Fields" for the purpose of CPRP qualified individuals.

Statute, Rule, or Variance	Notes on the definition
Rule 9505.0260	Refers to 9505.0175, adds LMFT back in, omits LPCC
Duplicates/Cross References	
256B.0943 subd 1. (CTSS)	Refers to R47 9505.0370
256B.0622 subd 7a. (ACT)	Refers to R47 9505.0371
256B.0622 subd 2. (IRTS)	Refers to 245.462 Subd 18 clauses (1-6)
256B.0946 subd 1a. (ITFC)	Refers to R47 9505.0370
9520.0760 Subp. 18 (Rule 29)	Refers to 245.462 Subd 18, includes allied fields.
256B.0624 Subd 5. (Adult Crisis)	Refers to 245.462 Subd 18 clauses (1-6)
256.0944 Subd 5 (Children Crisis)	Refers to CTSS
9505.0370 (Rule 47)	Internal cross reference to 9505.0371
256B.0947 (YACT)	Refers to R47 9505.0371
PRTF Variance	Refers to 245.4871 Subd 27, clauses (1-6)
IRTS Variance	Refers to ARMHS
62A.671	Refers to Mental Health Acts, includes allied fields.
125A.0942	Refers to Mental Health Acts, includes allied fields.
144.1501	Refers to Mental Health Acts, includes allied fields.
144.1505	Refers to Mental Health Acts, includes allied fields.

Statute, Rule, or Variance	Notes on the definition
148B.5301	Refers to Mental Health Acts
148E.0555	Refers to Mental Health Acts
148E.120	Refers to Mental Health Acts
245.470	Refers to Mental Health Acts
245.4863	Refers to R47 9505.0370
245.488	Refers to Mental Health Acts
245.8251	Refers to Mental Health Acts, includes allied fields.
245A.03	Refers to Mental Health Acts, includes allied fields.
254B.05	Refers to Mental Health Acts
256B.092	Refers to Mental Health Acts, includes allied fields.
256B.0941	Refers to Mental Health Acts
256B.0949	Refers to Mental Health Acts
256B.49	Refers to Mental Health Acts, includes allied fields.
Rules 2960.0020	Refers to Mental Health Acts, includes allied fields.
Rule 5300.0150	Omits LPCC, otherwise refers to Mental Health Acts
Rules 7410.0700	Refers to Mental Health Acts, includes allied fields.
Rule 9500.1452	Refers to Mental Health Acts, includes allied fields.

Statute, Rule, or Variance	Notes on the definition
Rule 9520.0902	Refers to Mental Health Acts, includes allied fields. Also adds clinical trainees.
Rule 9530.6620	Refers to Mental Health Acts, includes allied fields.
Rule 9535.4010	Refers to Mental Health Acts, includes allied fields.
Rule 944.0020	Refers to Mental Health Acts, includes allied fields.
Rule 9585.0040	Refers to Mental Health Acts, includes allied fields.

Clinical Trainee

Proposed	Current (Compared to 9505.0371 Subp 5, other definitions found in Adult/Children's MH Acts, as well as several service lines.)	Notes (This section is still under development, and will have more detail by Jan 3.
(a) A clinical trainee is a staff person who is enrolled in or has completed an accredited graduate program of study intended to prepare the individual for independent licensure as a mental health professional and who:	(3) is a graduate student in one of the mental health professional disciplines defined in item A and is formally assigned by an accredited college or university to an agency or facility for clinical training; (4) holds a master's or other graduate degree in one of the mental health professional disciplines defined in item A from an accredited college or university; or	
(1) participates in a practicum or internship supervised by a mental health professional;	(1) the mental health practitioner is: (a) complying with requirements for licensure or board certification as a mental health professional, as defined in item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or	

Proposed	Current (Compared to 9505.0371 Subp 5, other definitions found in Adult/Children's MH Acts, as well as several service lines.)	Notes (This section is still under development, and will have more detail by Jan 3.
or (2) is completing postgraduate hours, according to the requirements of a health-related licensing board.	(b) a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional defined in item A; and	
	(2) the mental health practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of: (a) direct practice; (b) treatment team collaboration; (c) continued professional learning; and (d) job management.	
(b) A clinical trainee is responsible for notifying and applying to a health-related licensing board to ensure the requirements of the health-related licensing board are met. As permitted by a health-related licensing board, treatment oversight under this chapter may be integrated into a plan to meet the supervisory requirements of the health-related licensing board but does not supersede those requirements.		This is an existing requirement, per the health licensing boards. Notice is given here to avoid unintentional infractions which have occurred in the past.

Mental Health Practitioner

Proposed	Current (Compared to 245.462 Subd 17)	Notes (This section is still under development, and will have more detail by Jan 3.
(a) An individual who is qualified in at least one of the ways described in paragraphs (b) to (g) may serve as a mental health practitioner. A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults.	"Mental health practitioner" means a person providing services to adults with mental illness or children with emotional disturbance who is qualified in at least one of the ways described in paragraphs (b) to (g). A mental health practitioner for a child client must have training working with children. A mental health practitioner for an adult client must have training working with adults.	
(b) An individual is qualified through relevant coursework if the individual completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and: (1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; (2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the individual's clients belong, completes 40 hours of training in the delivery of services to adults	(b) For purposes of this subdivision, a practitioner is qualified through relevant coursework if the practitioner completes at least 30 semester hours or 45 quarter hours in behavioral sciences or related fields and: (1) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; (2) is fluent in the non-English language of the ethnic group to which at least 50 percent of the practitioner's clients belong, completes 40 hours of training in the delivery of services to adults with mental illness or children with emotional	

Proposed	Current (Compared to 245.462 Subd 17)	Notes (This section is still under development, and will have more detail by Jan 3.
with mental illness or children with emotional disturbance, and receives clinical supervision from a mental health professional at least once per week until the requirement of 2,000 hours of supervised experience is met; (3) is working in a day treatment program under section 245.4712, subdivision 2; or (4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.	disturbance, and receives clinical supervision from a mental health professional at least once a week until the requirement of 2,000 hours of supervised experience is met; (3) is working in a day treatment program under section 245.4712, subdivision 2; or (4) has completed a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.	
(c) An individual is qualified through work experience if the individual: (1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or (2) has at least 2,000 hours of supervised experience in the	(c) For purposes of this subdivision, a practitioner is qualified through work experience if the person: (1) has at least 4,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, substance use disorder, or emotional disturbance; or (ii) traumatic brain injury or developmental disabilities and completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; or	

Proposed	Current (Compared to 245.462 Subd 17)	Notes (This section is still under development, and will have more detail by Jan 3.
delivery of services to adults or children with: (i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional at least once per week until the requirement of 4,000 hours of supervised experience is met; or (ii) traumatic brain injury or developmental disabilities, completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects, and receives clinical supervision as required by applicable statutes and rules at least once per week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.	(2) has at least 2,000 hours of supervised experience in the delivery of services to adults or children with: (i) mental illness, emotional disturbance, or substance use disorder, and receives clinical supervision as required by applicable statutes and rules from a mental health professional at least once a week until the requirement of 4,000 hours of supervised experience is met; or (ii) traumatic brain injury or developmental disabilities; completes training on mental illness, recovery from mental illness, mental health de-escalation techniques, co-occurring mental illness and substance abuse, and psychotropic medications and side effects; and receives clinical supervision as required by applicable statutes and rules at least once a week from a mental health professional until the requirement of 4,000 hours of supervised experience is met.	
(d) An individual is qualified by a bachelor's or master's degree if the individual: (1) holds a master's or other graduate degree in behavioral sciences or related fields; or (2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.	e) For purposes of this subdivision, a practitioner is qualified by a bachelor's or master's degree if the practitioner: (1) holds a master's or other graduate degree in behavioral sciences or related fields; or (2) holds a bachelor's degree in behavioral sciences or related fields and completes a practicum or internship that (i) requires direct interaction with adults or children served, and (ii) is focused on behavioral sciences or related fields.	

Proposed	Current (Compared to 245.462 Subd 17)	Notes (This section is still under development, and will have more detail by Jan 3.
Subdivision 1. Tribal Providers. A tribal entity may exercise the provision of section 256B.02, subd. 7, paragraphs b and c, to credential an individual in one of the roles defined by this section.	(f) For purposes of this subdivision, a practitioner is qualified as a vendor of medical care if the practitioner meets the definition of vendor of medical care in section 256B.02, subdivision 7, paragraphs (b) and (c), and is serving a federally recognized tribe.	
	(g) For purposes of medical assistance coverage of diagnostic assessments, explanations of findings, and psychotherapy under section 256B.0625, subdivision 65, a mental health practitioner working as a clinical trainee means that the practitioner's clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of direct practice, treatment team collaboration, continued professional learning, and job management. The practitioner must also: (1) comply with requirements for licensure or board certification as a mental health professional, according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A, including supervised practice in the delivery of mental health services for the treatment of mental illness; or (2) be a student in a bona fide field placement or internship under a program leading to completion of the requirements for licensure as a mental health professional according to the qualifications under Minnesota Rules, part 9505.0371, subpart 5, item A.	Covered separately in clinical trainee.
	(h) For purposes of this subdivision, "behavioral sciences or related fields" has the meaning given in section 256B.0623, subdivision 5, paragraph (d).	Will be defined in 245.02
	(i) Notwithstanding the licensing requirements established by a health-related licensing board, as defined in section 214.01, subdivision 2, this	No longer required. Conflicts addressed by repeal of Rule 47 and

Proposed	Current (Compared to 245.462 Subd 17)	Notes (This section is still under development, and will have more detail by Jan 3.
	subdivision supersedes any other statute or rule.	other conflicting definitions.

Certified rehabilitation specialist

Proposed	Current (Compared to 256B.0623 Subd 5)	Notes (This section is still under development, and will have more detail by Jan 3.
A certified rehabilitation specialist shall have: 1. a master's degree from an accredited college or university in behavioral sciences or related fields as defined in section 245I.02, subdivision 2; 2. at least 4,000 hours of postmaster's supervised experience in the delivery of mental health services; and **3.** a valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.	the definition of mental health professional for purposes of this section includes a person who is qualified under section 245.462, subdivision 18, clause (7), and who holds a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner;	

MH Family Peer

Proposed (See 245.696 for what DHS must do, and 245I.16 for how an individual qualifies) Under development, will have more detail by Jan. 3	Current (Compared to 256B.0616)	Notes (This section is still under development, and will have more detail by Jan 3.
	Subdivision 1. Scope.	

Proposed (See 245.696 for what DHS must do, and 245I.16 for how an individual qualifies) Under development, will have more detail by Jan. 3	Current (Compared to 256B.0616)	Notes (This section is still under development, and will have more detail by Jan 3.
	Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who have an emotional disturbance or severe emotional disturbance under chapter 245, and are provided by a certified family peer specialist who has completed the training under subdivision 5. A family peer specialist cannot provide services to the peer specialist's family.	
	Subd. 2. Establishment. The commissioner of human services shall establish a certified family peer specialists program model which: (1) provides nonclinical family peer support counseling, building on the strengths of families and helping them achieve desired outcomes; (2) collaborates with others providing care or support to the family; (3) provides nonadversarial advocacy; (4) promotes the individual family culture in the treatment milieu; (5) links parents to other parents in the community; (6) offers support and encouragement; (7) assists parents in developing coping mechanisms and problem-solving skills;	

Proposed (See 245.696 for what DHS must do, and 245I.16 for how an individual qualifies) Under development, will have more detail by Jan. 3	Current (Compared to 256B.0616)	Notes (This section is still under development, and will have more detail by Jan 3.
	(8) promotes resiliency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services; (9) establishes and provides peer-led parent support groups; and (10) increases the child's ability to function better within the child's home, school, and community by educating parents on community resources, assisting with problem solving, and educating parents on mental illnesses.	
	§ Subd. 3. Eligibility. Family peer support services may be located in inpatient hospitalization, partial hospitalization, residential treatment, treatment foster care, day treatment, children's therapeutic services and supports, or crisis services.	
	Subd. 4. Peer support specialist program providers. The commissioner shall develop a process to certify family peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Family peer support programs must operate within an existing mental health community provider or center.	
	Subd. 5. Certified family peer specialist training and certification. The commissioner shall develop a training and certification process for certified	

Proposed (See 245.696 for what DHS must do, and 245I.16 for how an individual qualifies) Under development, will have more detail by Jan. 3	Current (Compared to 256B.0616)	Notes (This section is still under development, and will have more detail by Jan 3.
	family peer specialists who must be at least 21 years of age. The candidates must have raised or be currently raising a child with a mental illness, have had experience navigating the children's mental health system, and must demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer specialists specific skills relevant to providing peer support to other parents. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.	

MH Peer

Proposed (See 245.696 for what DHS must do, and 245I.16 for how an individual qualifies) Under development, will have more detail by Jan. 3	Current (Compared to 256B.0615)	Notes (This section is still under development, and will have more detail by Jan 3.
	Subdivision 1.Scope. Medical assistance covers mental health certified peer specialist services, as established in subdivision 2, subject to federal approval, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, and 256B.0624 and are provided by a certified peer specialist who has completed the training under subdivision 5.	
	Subd. 2.Establishment.	

Proposed (See 245.696 for what DHS must do, and 245I.16 for how an individual qualifies) Under development, will have more detail by Jan. 3	Current (Compared to 256B.0615)	Notes (This section is still under development, and will have more detail by Jan 3.
	The commissioner of human services shall establish a certified peer specialist program model, which: (1) provides nonclinical peer support counseling by certified peer specialists; (2) provides a part of a wraparound continuum of services in conjunction with other community mental health services; (3) is individualized to the consumer; and (4) promotes socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.	
	Subd. 3.Eligibility. Peer support services may be made available to consumers of (1) intensive residential treatment services under section 256B.0622; (2) adult rehabilitative mental health services under section 256B.0623; and (3) crisis stabilization and mental health mobile crisis intervention services under section 256B.0624.	
	Subd. 4.Peer support specialist program providers. The commissioner shall develop a process to certify peer support specialist programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Peer support programs may be freestanding or within existing mental health community provider centers.	
	Subd. 5.Certified peer specialist training and certification.	

Proposed (See 245.696 for what DHS must do, and 245I.16 for how an individual qualifies) Under development, will have more detail by Jan. 3	Current (Compared to 256B.0615)	Notes (This section is still under development, and will have more detail by Jan 3.
	The commissioner of human services shall develop a training and certification process for certified peer specialists, who must be at least 21 years of age. The candidates must have had a primary diagnosis of mental illness, be a current or former consumer of mental health services, and must demonstrate leadership and advocacy skills and a strong dedication to recovery. The training curriculum must teach participating consumers specific skills relevant to providing peer support to other consumers. In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to peer support counseling.	

MH Rehabilitation Worker

Proposed (Please see 245I.16) Under development, more detail available Jan 3.	Current (Compared to 256B.0623 Subd 5)	Notes (This section is still under development, and will have more detail by Jan 3.
	(4) a mental health rehabilitation worker. A mental health rehabilitation worker means a staff person working under the direction of a mental health practitioner or mental health professional and under the clinical supervision of a mental health professional in the implementation of rehabilitative mental health services as identified in the recipient's individual treatment plan who: (i) is at least 21 years of age;	
	(ii) has a high school diploma or equivalent; (iii) has successfully completed 30 hours of training during the two years immediately prior to the date of hire, or before provision of direct services, in all of the following areas: recovery	

Proposed (Please see 245I.16) Under development, more detail available Jan 3.	Current (Compared to 256B.0623 Subd 5)	Notes (This section is still under development, and will have more detail by Jan 3.
	from mental illness, mental health de-escalation techniques, recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality; and (iv) meets the qualifications in paragraph (b). (b) In addition to the requirements in paragraph (a), a mental health rehabilitation worker must also meet the qualifications in clause (1), (2), or (3): (1) has an associates of arts degree, two years of full-time postsecondary education, or a total of 15 semester hours or 23 quarter hours in behavioral sciences or related fields; is a registered nurse; or within the previous ten years has: (i) three years of personal life experience with serious mental illness; (ii) three years of life experience as a primary caregiver to an adult with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability; or (iii) 2,000 hours of supervised work experience in the delivery of mental health services to adults with a serious mental illness, traumatic brain injury, substance use disorder, or developmental disability; (2)(i) is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong; (ii) receives during the first 2,000 hours of work, monthly documented individual clinical supervision by a mental health professional;	

Proposed (Please see 245I.16) Under development, more detail available Jan 3.	Current (Compared to 256B.0623 Subd 5)	Notes (This section is still under development, and will have more detail by Jan 3.
	(iii) has 18 hours of documented field supervision by a mental health professional or mental health practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year; (iv) has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or mental health practitioner; and (v) has 15 hours of additional continuing education on mental health topics during the first year of employment and 15 hours during every additional year of employment; or (3) for providers of crisis residential services, intensive residential treatment services, partial hospitalization, and day treatment services: (i) satisfies clause (2), items (ii) to (iv); and (ii) has 40 hours of additional continuing education on mental health topics during the first year of employment. (c) A mental health rehabilitation worker who solely acts and is scheduled as overnight staff is not required to comply with paragraph (a), clause (4), item (iv).	

MH Behavioral Aide

Proposed (Please see 245I.16) Under development, more detail available Jan 3.	Current (Compared to 256B.0943)	Notes (This section is still under development, and will have more detail by Jan 3.
	(A) A level I mental health behavioral aide must:	

Proposed (Please see 245I.16) Under development, more detail available Jan 3.	Current (Compared to 256B.0943)	Notes (This section is still under development, and will have more detail by Jan 3.
	(i) be at least 18 years old; (ii) have a high school diploma or commissioner of education-selected high school equivalency certification or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and (iii) meet preservice and continuing education requirements under subdivision 8. (B) A level II mental health behavioral aide must: (i) be at least 18 years old; (ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and (iii) meet preservice and continuing education requirements in subdivision 8.	

Appendix E – Individual Treatment Plan

	ARMHS	CTSS	RULE 47/PSYCHOTHERAPY/DBT
DEFINITION	**256B.0623, Subd. 10, clause (1)** Individual treatment plan means a plan of intervention, treatment, and services for an individual recipient [...] The [ITP] must be based on diagnostic and functional assessments.	**256B.0943, Subd. 1, paragraph (l).** "Individual treatment plan" has the meaning given in Minnesota Rules, part 9505.0371, subpart 7.	*More appropriately incorporated into required elements below*
REQUIRED ELEMENTS	**256B.0623, Subd. 1** refers to definition in **245.462, Subd. 14.** "Individual treatment plan" means a written plan of intervention, treatment, and services for an adult with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identifies goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsible for providing treatment to the adult with mental illness. **256B.0623, Subd. 10, clause (2)** The individual treatment plan must include: (i) a list of problems identified in the assessment; (ii) the recipient's strengths and resources; (iii) concrete, measurable goals to be achieved, including time frames for achievement; (iv) specific objectives directed toward the achievement of each one of the goals; (v) documentation of participants in the treatment planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the	Follow Rule 47 guidelines **(9505.0371, Subp. 7)** **256B.9043, Subd. 6, paragraph (b), clause (2)** developing an individual treatment plan that: (i) is based on the information in the client's diagnostic assessment and baselines; (ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports; (iii) is developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports; (iv) is developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning; (vi) is signed by the clinical supervisor and by the client	**9505.0370, Subp. 15.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency. **9505.0371, Subp. 7.** [...] A client's individual treatment plan must be: A. based on the client's current diagnostic assessment; B. developed by identifying the client's service needs and considering relevant cultural influences to identify planned interventions that contain specific treatment goals and measurable objectives for the client; and **9505.0372, Subp. 8.** Adult day treatment. paragraph (B), clause (5) [...] The individual treatment plan must include attainable, measurable goals as they relate to services [...] and include an available discharge plan for the client in the treatment plan

	ARMHS	CTSS	RULE 47/PSYCHOTHERAPY/DBT
	treatment plan, or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient or legal guardian. Referral to formal services must be arranged, including specific providers where applicable; (vi) cultural considerations, resources, and needs of the recipient must be included; (vii) planned frequency and type of services must be initiated; and (viii) clear progress notes on outcome of goals.	or by the client's parent or other person authorized by statute to consent to mental health services for the client. A client's parent may approve the client's individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature;	
PROCESS	**256B.0623, Subd. 10, clause (1)** […] To the extent possible, the development and implementation of a treatment plan must be a collaborative process involving the recipient, and with the permission of the recipient, the recipient's family and others in the recipient's support system. **256B.0623, Subd. 10, clause (3)** The individual community support plan defined in section 245.462, subdivision 12, may serve as the individual treatment plan if there is involvement of a mental health case manager, and with the approval of the recipient. The individual community support plan must include the criteria in clause (2). **256B.0623, Subd. 4, paragraph (f), clauses (6-7; 9)** (6) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;	Follow Rule 47 guidelines **(9505.0371, Subp. 7)** **256B.0943, Subd. 1, paragraph (p), clause (1)** the development, review, and revision of a child's individual treatment plan, as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of the client or client's parents, primary caregiver, or other person authorized to consent to mental health services for the client, and including arrangement of treatment and support activities specified in the individual treatment plan **256B.9043, Subd. 9, paragraph (b), clause (6)** mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by	**9505.0371, Subp. 7.** [...] The client must be involved in the development, review, and revision of the client's ITP. The mental health professional or practitioner shall request the client, or other person authorized by statute to consent to mental health services for the client, to sign the client's ITP or revision of the ITP. In the case of a child, the child's parent, primary caregiver, or other person authorized by statute to consent to mental health services for the child shall be asked to sign the child's ITP and revisions of the ITP. If the client or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner shall note on the plan the refusal to sign the plan and the reason or reasons for the refusal.

	ARMHS	CTSS	RULE 47/PSYCHOTHERAPY/DBT
	(7) ensure that the mental health professional or mental health practitioner, who is under the clinical supervision of a mental health professional, involved in a recipient's services participates in the development of the individual treatment plan; (9) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;	the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to review, revise, and sign the individual treatment plan. Notwithstanding Minnesota Rules, part 9505.0371, subpart 7, medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development	
TIMELINE	**256B.0623, Subd 10, clause (1)** Providers of adult rehabilitative mental health services must develop the individual treatment plan within 30 calendar days of intake. The treatment plan must be updated at least every six months thereafter, or more often when there is significant change in the recipient's situation or functioning, or in services or service methods to be used, or at the request of the recipient or the recipient's legal guardian.	**9505.0371, Subp. 7.** For all mental health services, except as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. **256B.0371, Subd. 6, paragraph (b), clause (2)(v).** […] is reviewed at least once every 90 days and revised to document treatment progress on each treatment objective and next goals or, if progress is not documented, to document changes in treatment; **9505.0371, Subp. 7, paragraph (c).** [ITP must be] reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan	**9505.0371, Subp. 7.** For all mental health services, except as provided in subpart 2, item A, subitem (1), and medication management, the ITP and subsequent revisions of the ITP must be signed by the client before treatment begins. **9505.0371, Subp. 7, paragraph (c).** [ITP must be] reviewed at least once every 90 days, and revised as necessary. Revisions to the initial individual treatment plan do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2. **9505.0372, Subp. 8, paragraph (b), clause (5).** [The ITP] must be completed before the first day treatment session. The vendor must review the recipient's progress and update the treatment plan at least every 30 days until the client is discharged

	ARMHS	CTSS	RULE 47/PSYCHOTHERAPY/DBT
		do not require a new diagnostic assessment unless the client's mental health status has changed markedly as provided in subpart 2.	
ELIGIBLE PROVIDERS	**256B.0623, Subd 10, clause (1)** mental health professional or by a mental health practitioner under the clinical supervision of a mental health professional	**9505.0371, Subp. 7.** mental health professional or practitioner	mental health professional or practitioner

	RULE 29/CMHC	IRTS	MOBILE AND RESIDENTIAL CRISIS
DEFINITION	**9520.0760, Subp. 16.** "Individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results for a specific client, and updated as necessary. The plan specifies the goals and objectives in measurable terms, states the treatment strategy, and identifies responsibilities of multidisciplinary staff.	**256B.0622, Subd. 2, paragraph (d).** "Individual treatment plan" means the document that results from a person-centered planning process of determining real-life outcomes with clients and developing strategies to achieve those outcomes. **IRTS Variance, R36V.03, Subd. 17.** "Individual treatment plan" or "ITP" means a written plan of mental health treatment developed based on the assessment of the recipient's needs and revised as necessary. The plan specifies goals and objectives and interventions to achieve the objectives. The plan also identifies the staff who are responsible to provide the interventions.	**256B.0624, Subd. 6, paragraph (d)** [...] The plan must address the needs and problems noted in the crisis assessment and include measurable short-term goals, cultural considerations, and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis. The treatment plan must be updated as needed to reflect current goals and services.
REQUIRED ELEMENTS	**9520.0790, Subp. 4.** Clinical services shall be appropriate to the condition, age, sex, socioeconomic, and ethnic background of the client, and provided in the least restrictive manner. […]	**IRTS Variance, R36V.04, Subd. 3:** (h) […] The ITP must include: (1) The recovery goal or goals identified by the recipient; (2) A minimum of one discharge goal that identifies what the recipient needs in order to successfully transition to a less restrictive environment; (3) Objectives that support the discharge goal and can be	**245.991 (SF1291): Subd.8, paragraph (b)** The crisis intervention treatment plan must: (1) address the recipient's needs and problems noted in the assessment; (2) include measurable short-term goals;

	RULE 29/CMHC	IRTS	MOBILE AND RESIDENTIAL CRISIS
		accomplished within 30 days based on the recipient's strengths and resources; (4) Interventions that will be provided by staff to address each objective, including interventions for treatment of a co-occurring substance abuse disorder treatment, when needed; (5) Interventions related to engaging recipients in treatment if they have a history of non-compliance with treatment and are court ordered to receive treatment or neuroleptic medications; (6) Identification of the staff who are responsible to deliver the interventions and frequency of the interventions; (7) Identification of referrals and resources needed to assure the recipient's health and safety needs are met and the staff who are responsible to assure that appropriate follow-up occurs. If a recipient does not receive a needed service, the license holder must document the reason and determine whether additional follow-up is required; (8) The date it was completed or updated; (9) The recipient's signature to acknowledge his or her participation in development or the revisions of their ITP. If the recipient refuses to participate in the development of their ITP or subsequent revisions, the refusal must be documented in the recipient's individual file. In this circumstance, the interventions that were used to engage the recipient in the development or revision of their ITP must also be documented in the recipient's individual file; (10) The recipient's signature to acknowledge receipt of their	(3) address cultural considerations; (4) specify the frequency and type of services to be provided to achieve the recipient's goals and reduce or eliminate the crisis; and (5) be updated as needed to reflect current goals and services. **256B.0624, Subd. 11** The individual crisis stabilization treatment plan must include, at a minimum: (1) a list of problems identified in the assessment; (2) a list of the recipient's strengths and resources; (3) concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement; (4) specific objectives directed toward the achievement of each one of the goals; (5) documentation of the participants involved in the service planning. The recipient, if possible, must be a participant. The recipient or the recipient's legal guardian must sign the service plan or documentation must be provided why this was not possible. A copy of the plan must be given to the recipient and the recipient's legal guardian. The plan should include services arranged, including specific providers where applicable; (6) planned frequency and type of services initiated;

	RULE 29/CMHC	IRTS	MOBILE AND RESIDENTIAL CRISIS
		initial ITP and all subsequent ITPs. If the recipient refuses to sign to acknowledge receipt of their ITP, the refusal must be documented in the recipient's individual file; and, (11) The signature and title of the mental health practitioner who completed or updated the ITP and the signatures of the treatment director and the clinical supervisor who reviewed the ITP and any changes to the ITP and the date of their review.	(7) a crisis response action plan if a crisis should occur; (8) clear progress notes on outcome of goals; (10) a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.
PROCESS	**9520.0790, Subp. 4.** The individual treatment plan, based upon a diagnostic assessment of mental illness, shall be jointly developed by the client and the mental health professional. This planning procedure shall ensure that the client has been informed in the following areas: assessment of the client condition; treatment alternatives; possible outcomes and side effects of treatment; treatment recommendations; approximate length, cost, and hoped-for outcome of treatment; the client's rights and responsibilities in implementation of the individual treatment plan; staff rights and responsibilities in the treatment process; the Government Data Practices Act; and procedures for reporting grievances and alleged violation of client rights. If the client is considering chemotherapy, hospitalization, or other medical treatment, the appropriate medical staff person shall inform the client of the treatment alternatives, the effects of the medical procedures, and possible side effects.	**IRTS Variance, R36V.04, Subd. 3:** (h) Interpretive summary. Within ten days of admission, a mental health professional or a mental health practitioner with clinical supervision must synthesize information from the recipient about his or her preferences and goals, from the recipient's current assessments, and other available information in a written interpretive summary [which must include]: (1) The recipient's recovery goal or goals; (2) The recipient's diagnosis, including current symptoms and how they relate to the recipient's functional impairments; (3) The supports and services needed by the recipient to promote success after discharge; (4) Treatment plan priorities; and, (5) Recommended treatment interventions based on the recipient's strengths, resources, and needs. (i) Initial treatment plan must be refined and further developed as the ITP based on the interpretive summary. [...] Treatment planning must include the recipient and must be focused on the recipient's successful transition from the intensive residential service. The	

	RULE 29/CMHC	IRTS	MOBILE AND RESIDENTIAL CRISIS
		treatment planning must also include participation by or input from the recipient's family and case manager as permitted by the recipient.	
TIMELINE	No timeline specified.	**256B.0622, Subd. 5a., paragraph (h).** The initial individual treatment plan must be completed within 24 hours of admission. Within ten days of admission, the initial treatment plan must be refined and further developed, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the client and updated at least monthly. **IRTS Variance, R36V.04, Subd. 3, paragraph (b).** An initial treatment plan must be completed within 24 hours of the recipient's admission. [...] The initial treatment plan may be expanded to meet the requirements of the individual treatment plan (ITP). **IRTS Variance, R36V.04, Subd. 3, paragraph (i).** Within ten days of admission, the initial treatment plan must be refined and further developed as the ITP based on the interpretive summary, and must be updated at least every 30 days.	**256B.0624, Subd. 11, clause (9)** a written plan must be completed within 24 hours of beginning services with the recipient **245.991 (SF1291): Subd.8, paragraph (b)** The crisis team must develop a crisis intervention treatment plan as soon as appropriate but no later than 24 hours after the initial face-to-face intervention
ELIGIBLE PROVIDERS	**9520.0790, Subp. 4.** mental health professional	**IRTS Variance, R36V.04, Subd. 3, paragraphs (b) and (i).** mental health professional or a mental health practitioner under clinical supervision	**256B.0624, Subd. 11, clause (10)** a treatment plan must be developed by a mental health professional or mental health practitioner under the clinical supervision of a mental health professional. The mental health professional must approve and sign all treatment plans.

	ACT	YACT	IFTC
DEFINITION	**256B.0622, Subd. 2 (d).** "Individual treatment plan" means the document that results from a person-centered planning process of determining real-life outcomes with clients and developing strategies to achieve those outcomes.	**256B.0947, [refers to 256B.0943, Subd. 6, paragraph (b), clause (2)]** developing an individual treatment plan that: (i) is based on the information in the client's diagnostic assessment and baselines; (ii) identified goals and objectives of treatment, treatment strategy, schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment services and supports; (iv) is developed through a child-centered, family-driven, culturally appropriate planning process, including allowing parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning;	**256B.0946, Subd. 1a., paragraph (l).** "Individual treatment plan" has the meaning given in Minnesota Rules, part 9505.0370, subpart 15. **9505.0370, Subp. 15.** "Individual treatment plan" means a written plan that outlines and defines the course of treatment. It delineates the goals, measurable objectives, target dates for achieving specific goals, main participants in treatment process, and recommended services that are based on the client's diagnostic assessment and other meaningful data that are needed to aid the client's recovery and enhance resiliency.
REQUIRED ELEMENTS	**256B.0622, Subd. 7d, paragraph (h), clause (3)** Each client's individual treatment plan shall identify service needs, strengths and capacities, and barriers, and set specific and measurable short- and long-term goals for each service need. The individual treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals, when the interventions shall happen, and identify which ACT team member shall carry out the approaches and interventions.	**256B.0947, Subd. 6, paragraph (d)** An individual treatment plan must be completed for each client, according to criteria specified in section 256B.0943, subdivision 6, paragraph (b), clause (2), and, additionally, must: (2) if a need for substance use disorder treatment is indicated by validated assessment: (i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports; (4) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent	**256B.0946, Subd. 4, paragraph (e).** Each client receiving treatment must be assessed for a trauma history, and the client's treatment plan must document how the results of the assessment will be incorporated into treatment. **256B.0946, Subd. 4, paragraph (n).** Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and post discharge mental health service needs.

	ACT	YACT	IFTC
		providers in the transition to less intensive or "stepped down" services.	
PROCESS	**256B.0622, Subd. 7a, paragraph (c)** Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. **256B.0622, Subd. 7d, paragraph (e)** Between 30 and 45 days after the client's admission to assertive community treatment, the entire ACT team must hold a comprehensive case conference, where all team members, including the psychiatric provider, present information discovered from the completed in-depth assessments and provide treatment recommendations. The conference must serve as the basis for the first six-month treatment plan, which must be written by the primary team member. **256B.0622, Subd. 7d, paragraph (h)** Individual treatment plans must be developed through the following treatment planning process: (1) The individual treatment plan shall be developed in collaboration with the client and the client's preferred natural supports, and guardian, if applicable and appropriate. The ACT team shall evaluate, together with each client, the client's needs, strengths, and preferences and develop the individual treatment plan collaboratively. The ACT team shall make every effort to ensure that the client and the client's family and natural	**256B.0947, Subd. 6, paragraph (d)** An individual treatment plan must be completed for each client, according to criteria specified in section 256B.0943, subdivision 6, paragraph (b), clause (2), and, additionally, must: (1) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community; (2) if a need for substance use disorder treatment is indicated by validated assessment: -(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports; (3) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and	**256B.0946, Subd. 4, paragraph (d).** Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received. This information must be reviewed and incorporated into the diagnostic assessment and team consultation and treatment planning review process. **256B.0946, Subd. 4, paragraph (f).** [ITP must be] reviewed, evaluated, and signed [...] using the team consultation and treatment planning process, as defined in subdivision 1a, paragraph (s): "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

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	supports, with the client's consent, are in attendance at the treatment planning meeting, are involved in ongoing meetings related to treatment, and have the necessary supports to fully participate. The client's participation in the development of the individual treatment plan shall be documented. (2) The client and the ACT team shall work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment, rehabilitation, and support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the client, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the client. The process supports strengths, rehabilitation, and recovery. (5) The primary team member shall prepare a summary that thoroughly describes in writing the client's and the individual treatment team's evaluation of the client's progress and goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last individual treatment plan. The client's most recent diagnostic assessment must be included with the treatment plan summary. (6) The individual treatment plan and review must be signed or acknowledged by the client, the primary team member, the team leader, the psychiatric care provider, and all individual treatment team members. A copy of the signed individual		

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	treatment plan is made available to the client.		
TIMELINE	**256B.0622, Subd. 7d., paragraph (a)** a 30-day treatment plan shall be completed the day of the client's admission to assertive community treatment **256B.0622, Subd. 7d. paragraph (h), clause (4)** The primary team member and the individual treatment team, together with the client and the client's family and natural supports with the client's consent, are responsible for reviewing and rewriting the treatment goals and individual treatment plan whenever there is a major decision point in the client's course of treatment or at least every six months.	**256B.0943, Subd. 6, paragraph (b), clause (2)** (iii) is developed after completion of the client's diagnostic assessment by a mental health professional or clinical trainee and before the provision of children's therapeutic services and supports; (v) [...] reviewed at least once every 90 days **256B.0947, Subd. 6, paragraph (d), clause (2)** if a need for substance use disorder treatment is indicated by validated assessment: (i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports; (ii) be reviewed at least once every 90 days and revised, if necessary;	**256B.0946, Subd. 4, paragraph (f).** Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and signed every 90 days
ELIGIBLE PROVIDERS	**256B.0622, Subd. 7d., paragraph (a)** the ACT team leader or the psychiatric care provider, with participation by designated ACT team members and the client. • ACT team leader (Subd. 7a, (a)(1)(i)): licensed mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role but must obtain full licensure within 24 months of assuming the role of team leader • Psychiatric care provider (Subd. 7a, (a)(2)(i)): licensed psychiatrist certified by the	Not specified	Not specified

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	American Board of Psychiatry and Neurology or eligible for board certification or certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness		