9525.0024 CASE MANAGEMENT SERVICE PRACTICE STANDARDS.

Subpart 1. **Assessment of individual needs.** The case manager shall assess or arrange for an assessment of the functional skills and needs of the person and the supports and services which meet the person's identified needs and preferences. Assessment information obtained by other providers, including schools and vocational rehabilitation agencies, may be used to meet the assessment requirements of this subpart. This subpart does not require assessment in areas agreed to as unnecessary by the case manager and the person, or the person's legal representative, or when there has been functional assessment completed in the previous 12 months, for which the case manager and the person or the person's legal representative agree that further assessment is not necessary. Where the county is acting as public guardian, the case manager shall seek authorization from the public guardianship office for waiving any assessment requirements. Assessments related to health, safety, and protection of the person for the purpose of identifying service type, amount, and frequency, or assessments required to authorize services, must not be waived.

The assessment of the person's preference, functional skills, and need for services and supports must address the following areas:

A. basic needs: income or support, money management, shelter, food, clothing, and assistive technology and adaptations;

B. health and safety: physical and dental health, vision, hearing, medication management, mental health and emotional well-being, and ability to keep oneself safe;

C. social skills and interpersonal relationships;

D. communication skills;

E. self-care: toileting, eating, dressing, hygiene, and grooming;

F. home living skills: clothing care, housekeeping, food preparation and cooking, shopping, daily schedule, and home maintenance;

G. community use: transportation and mobility, leisure and recreation, and other community resources;

H. employment/vocational skills;

I. educational skills/cognitive abilities; and

J. legal representation.

Subp. 2. **Review of person's needs for services and support.** The case manager shall review the assessment information as it becomes available through program evaluation and monitoring, provider reports, team meetings, and other sources of formal or informal assessment. The service planning team shall also review the assessment information at least annually for purposes of making modifications to the person's individual service plan

for needed services and supports. The case manager shall coordinate the performance of assessments. This subpart does not require duplication of assessment responsibilities fulfilled by providers. The case manager shall assure that the person's medical status and ongoing health care needs are assessed annually when not otherwise arranged by family or service providers.

Subp. 3. **Individual service plan development.** The designated case manager, who is familiar with the person and the person's need for services and supports, shall lead the individual service planning team activities. Annual service planning activities must result in the development or revision and implementation of the person's individual service plan. Individual service plans may be completed on forms developed for interagency planning, such as transition and individual family service plans, if they contain the components required under items A to K.

The written individual service plan must contain:

A. the person's preferences for services as stated by the person or the person's legal representative;

B. the person's service and support needs based on results of assessment information, including identification of needs that are currently met in whole or in part by the person's relatives, friends, and community services used by the general public;

C. the person's long- and short-range goals;

D. specific supports and services, including case management services, and the amount and frequency of the services to be provided to the person based on available resources, and the person's needs and preferences;

E. specification of services the person needs that are not available and actions to be taken to obtain or develop these services;

F. a determination of whether there is a need for an individual program plan developed by the provider according to applicable state and federal licensing and certification standards;

G. identification of additional assessments to be completed or arranged by the provider after service initiation;

H. specification of any information that providers or subcontractors must submit to the case manager, the frequency with which the information must be provided when not otherwise specified in contract, service agreement, or authorization form, and provider responsibilities to implement and make recommendations for modification to the individual service plan;

I. notice of the right to request a conciliation conference or a hearing under Minnesota Statutes, section 256.045;

J. signatures of the person, the person's legal representative, and the case manager at least annually and whenever changes are made; and

K. documentation that the plan was reviewed by a health professional if the person has overriding medical needs that impact the delivery of services.

Subp. 4. [Removed, L 2003 1SP14 art 11 s 11]

Subp. 5. **Identification of service options and providers.** Case managers shall assist the service planning team members in making informed choices of service options and providers by identifying for the team:

A. service types that would meet the level and frequency of services needed by the person, the funding streams, the general comparative costs, and the location;

B. resources and providers within the county or other areas if requested by the person or the person's legal representative, including resources not currently available;

C. provider capacities to meet assessed needs and preferences of the person, or to develop services if not immediately available; and

D. other community resources or services necessary to meet the person's or the person's family's needs.

The case manager may survey providers or may develop a request for a proposal to locate services. When the case manager is unable to locate appropriate service providers, the case manager shall indicate this in the person's individual service plan. The case manager shall follow county procedures for:

(1) maintaining unmet need or waiting list information according to Minnesota Statutes, section 256B.092, subdivision 1f;

(2) community social service planning activities; and

(3) developing additional resources.

Subp. 6. **Assisting the person to access services.** The case manager shall assist the person in accessing selected housing, services, and supports through the following activities:

A. coordinating the application process and preplacement planning activities and visits;

B. assuring that financial arrangements, contracts, or provider agreements are in place;

C. promoting the person's access to services that fit the person's needs;

D. assisting the person in securing the services identified in the individual service plan, including services not currently available; and

E. participating with the interdisciplinary team in the development of individual program plans that are consistent with the person's individual service plan.

Subp. 7. **Coordination of service delivery.** The case manager shall assure coordinated approaches to services among providers that are consistent with all aspects of the person's individual service plan. Before the initiation of service, and at least annually thereafter, the case manager shall make available to and may review with the providers the person's individual service plan. The case manager shall participate in interdisciplinary team meetings and maintain contact with providers sufficient to facilitate coordination and cooperation necessary to meet the person's needs.

Subp. 8. **Monitoring and evaluation activities.** The case manager shall specify the frequency of monitoring and evaluation activities in the person's individual service plan based on the level of need of the person and other factors which might affect the type, amount, or frequency of service. The case manager shall conduct a monitoring visit with each person on at least a semiannual basis. Case manager monitoring and evaluation activities must result in a determination of:

A. whether services are implemented consistent with the person's service plan, and are directed at achieving the goals identified for the person, and are consistent with the goals specified under part 9525.0008, subpart 3;

B. changes needed in the individual service plan to achieve desired outcomes or meet newly identified needs, including changes resulting from the recommendations of providers;

C. the extent to which providers are fulfilling their responsibilities and coordinating approaches to services with other providers;

D. the assurance of the person's health and safety;

E. the protection of the person's civil and legal rights; and

F. whether the person and the person's legal representative are satisfied with the services received.

If the provider fails to carry out the provider's responsibilities consistent with the individual service plan or develop an individual program plan when needed, the case manager shall notify the provider and, as necessary, the interdisciplinary team. If the concerns are not resolved by the provider or interdisciplinary team, the case manager shall notify the person or the person's legal representative, the appropriate licensing and certification agencies, and the county board where services are being provided. The case manager shall identify other steps needed to assure that the person receives the needed services and protections.

Statutory Authority: *MS s 256B.092*

History: *18 SR 2244; L 2003 1Sp14 art 11 s 11*

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