Section 2

Jessica Kisling
Our guiding authorities

• CMS (Centers for Medicaid and Medicare) – a.k.a. the Feds
  • statute #

• State Statutes

• State Rules
§ 440.169 Case management services

(a) Case management services means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with §441.18 of this chapter.
§ 440.169 Case management services

(b) Targeted case management services means case management services furnished without regard to the requirements of § 431.50(b) of this chapter (related to statewide provision of services) and § 440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.
§ 440.169 Case management services.

(d) The assistance that case managers provide in assisting eligible individuals obtain services includes -

(1) Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:

(i) Taking client history.

(ii) Identifying the needs of the individual, and completing related documentation.

(iii) Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.
CMS Definition of Case Management

§ 440.169 Case management services

(2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

(i) Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.

(ii) Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.

(iii) Identifies a course of action to respond to the assessed needs of the eligible individual.
§ 440.169 Case management services

(3) Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
§ 440.169 Case management services

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:

(i) Services are being furnished in accordance with the individual's care plan.

(ii) Services in the care plan are adequate.

(iii) There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
245.487 CITATION; DECLARATION OF POLICY; MISSION.

Subdivision 1. Citation.

Sections 245.487 to 245.4889 may be cited as the "Minnesota Comprehensive Children's Mental Health Act."
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.
245.4881 CASE MANAGEMENT AND FAMILY COMMUNITY SUPPORT SERVICES.

Subdivision 1. Availability of case management services.

(a) The county board shall provide case management services for each child with severe emotional disturbance who is a resident of the county and the child's family who request or consent to the services. Case management services must be offered to a child with a serious emotional disturbance who is over the age of 18 consistent with section 245.4875, subdivision 8, or the child's legal representative, provided the child's service needs can be met within the children's service system.
Mn. Rule 9520.0902 DEFINITIONS

Subp. 3.

• Case manager.

• "Case manager" means an individual who is employed by the local agency or an entity that is under contract to the local agency to provide case management services under parts 9520.0900 to 9520.0926 and who, if providing case management services to a child with a severe emotional disturbance, meets the qualifications specified in Minnesota Statutes, section 245.4871, subdivision 4.
Case Management Cycle

Assessment:
Review diagnostic assessment, review screening tools, FA, level of care, and reassessment

Working Relationship:
Person-centered & Recovery-oriented

Planning:
Develop IFCSP, transition plan, and other plans as needed

Monitoring and Coordination:
Review of goal progress and effectiveness of services, resources, and supports

Referral and Linkage:
Implement the IFCSP, acquire resources, services, and natural supports
State of MN DHS CH TCM Policy

Fee for Service Approx. 20%

County or Tribal Nations with placement authority

CMH – MH services & needs

County or Tribal Nation when placement does not occur

CW – Foster Care placement requirements

MCO Approx. 70%

Contracted CM Agency No placement authority

Non-MA Funded Approx. 5%
Diagnostic Assessment

Case Manager supports Child and Family

Functional Assessment

Individual and Family Community Support Plan

Transition Plan

Other assessment and plans as needed

Case Closure

The Golden Thread
**Goal:** Implement multiple approaches to engaging the child and the family in change efforts

**Objectives:**

a. Identify stages of change and accompanying change facilitation strategies

b. Define “soft power” and apply it to case management work

c. Demonstrate the ability to use motivational interviewing skills
Engagement Strategies
How do you know if you are working harder than your client?

How do you know if your pacing is too fast?

What are the characteristics of an effective helper?
What makes you a good helper?

Core competencies of effective helpers:

• Intellectual curiosity and flexibility
• Open-mindedness
• Psychological health
• Belief in people’s capacity for change
• Appreciation of individual differences and cultural diversity

• Interest in providing human services
• Personal integrity and honesty
• Capacity for developing interpersonal skills (empathy, respect for others, connecting with others)
• Self-awareness
Engagement Strategies

• Why do people change?
  • To relieve pain or discomfort
  • To avoid greater pain
  • To experience fulfillment

• Timing is important

• Challenge: Taking responsibility for the outcome without taking the outcome personally
Think of a time you wanted to make a change!

What interfered with your efforts?

What was helpful to your efforts?

What was the outcome?

If you have sustained the change for at least one year, what has helped you stay on track?
Stage of Change Theory:

I. Precontemplation
II. Contemplation
III. Preparation
IV. Action
V. Maintenance
How do you know what stage someone is in? (Explain thoughts, feelings and behaviors that demonstrate each stage)
Engagement Strategies
Solution-Focused Approach
Engagement Strategies
Solution-Focused Approach

• People are separate from their problems

• There is more than one solution to every problem

• Focusing on the positive and on the future facilitates change in the desired direction

• Small change leads to bigger change

• No one knows a person better than they know themselves

• Looking for what is working and doing more of it

• If something is not working, doing something different
Engagement Strategies
Solution-Focused Approach: Miracle Question
• A philosophy for communicating and interacting with clients

• Utilizes “soft power”

• Person-centered, directive

• Values collaboration, facilitation, respect
What does person-first language look like?

What happens when you use person-first language?
Motivational Interviewing “DARES” person to find strength and resources within self to make desired changes

- **D**evelop Discrepancies
- **A**void Argumentation
- **R**oll with Change
- **E**xpress Empathy
- **S**upport Self-Efficacy
Change Talk

• “I want to...” “I will...” “I’m going to...”

• Handout: “Ten Strategies for Evoking Change Talk

Other Techniques

• Scaling Questions

• Decisional Balance Point

• Reframing
Engagement Strategies
Motivational Interviewing Videos
Identify one situation in which you felt “stuck”.

Apply some of the engagement strategies we learned today.
• What is the difference between cultural responsiveness, cultural humility, and/or cultural competency?

• How these terms will be used in this portion of the presentation
Name the “-isms”
Cultural Responsiveness

Why Included in Training:

“Browning of America”

Articles:

accepting referrals regarding people of color

Perception of “diversity training”
Cultural Responsiveness
Browning of America
Expanding Disparities:

• Maternal and Infant Health
• Physical Health
• Income
MN Children 0-5 Living Below Federal Poverty Level

Source: U.S. Census Bureau, American Community Survey, 2013-17 5-year estimates

% Living at or Below Poverty Line

- White
- Asian
- Hispanic
- American Indian
- Black
Expanding Disparities:

• Education
• Employment
• Juvenile Justice
Share of Adults (25+) with Bachelor’s Degree or Higher, 2016

Source: MN State Demographic Center Estimates, U.S. Census Bureau American Community Survey, 1-year Estimates

- **White**: 24% BA, 12% Graduate/Professional
- **Asian**: 23% BA, 19% Graduate/Professional
- **Hispanic**: 10% BA, 5% Graduate/Professional
- **American Indian**: 8% BA, 6% Graduate/Professional
- **Black**: 13% BA, 7% Graduate/Professional

<table>
<thead>
<tr>
<th>Group</th>
<th>% Adults with BA Degree</th>
<th>% Adults with Graduate or Professional Degree</th>
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<tbody>
<tr>
<td>White</td>
<td>24%</td>
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<td>13%</td>
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Incarceration Rate Ratios

Comparing White, Latino, and Black Populations

- White
- Latino
- Black

# Individuals Incarcerated

6/10/2019
What is your role as a case manager in all of these systems?

Education    Juvenile Justice    Employment

Family    Social
• Institutionalized Racism

• Prejudice

• Ethnocentrism (e.g., White Privilege)
"You don’t act black."

"But, you sound white."

"Can I touch your hair?"

"You’re lucky there’s affirmative action."

"You’re pretty in an exotic way."

"You don’t dress ghetto."

sheknows
Review

“Unpacking the Invisible Knapsack”
Cultural Responsiveness
White Privilege

What it Means to be White in US:

- Automatic access, legitimacy, and support
- Multiple advantages accrue to you simply as a product of being white
- Multiple disadvantages accrue to people not like you (e.g., people of color) simply because they aren’t white
- Freedom from the persistent stressor of race and racism another advantage
- White privilege doesn’t mean white people aren’t smart or haven’t worked hard. It means the deck is stacked.
If we accepted this as truth, what implications does this have on being a case manager and going into someone’s home?
Health and Healing Across Racial and Ethnic Groups:

• African Americans
• Native Americans
• Asian Americans
• Hispanic Americans
Poverty Walk
Cultural Responsiveness
Process Questions

What did you see about the intersection of race and socioeconomic status?

What feelings, thoughts, or behaviors did you experience?

What do you want to do with your response to this activity?
• In 2013 45.3 million people lived below the poverty line in the United States.

• That equals 14.5% of the population

• That is 2% more than in 2010 when the last Census Bureau statistics were released
How might socioeconomic status impact your interactions as a case manager?
Cultural Responsiveness

What was missing?
Cultural Responsiveness

The Genderbread Person v3.3

Gender is one of those things everyone thinks they understand, but most people don’t. Like inception. Gender isn’t binary. It’s not either/or. In many cases it’s both/and. A bit of this, a dash of that. This tasty little guide is meant to be an appetizer for gender understanding. It’s okay if you’re hungry for more. In fact, that’s the idea.

- **Gender Identity**
  - Woman-ness
  - Woman-ness
  - Woman-ness
  - Man-ness
  - Man-ness
  - Man-ness

- **Gender Expression**
  - Feminine
  - Masculine

- **Biological Sex**
  - Female-ness
  - Male-ness

- **Attraction**
  - Sexually Attracted to
    - Nobody
    - Women/Females/Femininity
    - Men/Males/Masculinity
  - Romantically Attracted to
    - Nobody
    - Women/Females/Femininity
    - Men/Males/Masculinity

For a bigger bite, read more at http://bit.ly/genderbread
Goal: Apply interviewing and observation skills to collect relevant client information.

Objectives:

a) Identify techniques (e.g., structuring statements, probing, reflection) that are conducive to effective interviewing.

b) Describe how observational data can be obtained and utilized.
Recall a time when you conducted an effective interview with a client. What made it successful?

Recall a time when you had difficulty conducting an interview with a client. What made it challenging?
Interview and Observation Skills
Characteristics of Interviews:

1) Distinct purpose
2) Joint undertaking
3) Both art and science
• Establishing rapport
• Structuring statements (generalize, normalize, and privatize)
• Listening
What role does non-verbal communication play in an interview?

What are some examples, or personal experiences, of misinterpreting non-verbal communication?

How does non-verbal communication interplay with the concept of cultural responsiveness?
Over 80% of all communication is non-verbal!

1. Direct eye contact
   readiness/willingness for interpersonal communication, attentiveness

2. Staring/fixed on a person or object
   confrontational, defiant, preoccupied, possible rigidity or anxiety

3. Lips pursed together
   stress, determination, anger, hostility

4. Shaking head from left to right
   disagreement, disapproval, disbelief

5. Slouching in chair, turning away from interviewer
   sadness, discouragement, resistance to discussion

6. Trembling, fidgety hands
   anxiety, anger

7. Foot-tapping
   impatience, anxiety

8. Whispering
   difficulty disclosing material

9. Silence
   reluctance to talk, preoccupation

10. Clammy hands, shallow breathing, pupil dilation
    fearfulness, arousal – positive (excitement, interest) or negative (anxiety, embarrassment), drug intoxication
• Formulating Questions

• Using Probes Effectively

• Encourage Appropriate Replies

• Accepting vs. Endorsing
Interview Topic:

What was your family’s beliefs related to food in celebrations?
Interview Skills
Facilitating Communication

• Reflection and Feedback
• Changing Topics
• Handling Silence
• Managing Hostility or Defensiveness
• Self-disclosure
Interview Skills
What to Avoid

• Interrupting
• Leading questions
• Use of jargon and “clinical” language
• Inauthentic presentation
• Improper use of questions (e.g., random probing)
• Embarrassing questions
• Drastic shifts in questioning
• Rambling questions
Don’t overlook the importance of the obvious!
Mn. Stats. 245.4871

**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
Mn. Stats. 245.4871, subd. 6

(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.
A diagnostic assessment (DA) is a written report that documents the clinical and functional face-to-face evaluation of a recipient’s mental health. The report must include the recipient’s:

- Nature, severity, and impact of behavioral disorders
- Functional Impairment
- Subjective Distress
- Strengths and resources

A diagnostic assessment is necessary to determine a recipient’s eligibility for mental health services.
The following mental health professionals may enroll as a Minnesota Health Care Programs (MHCP) provider and render a diagnostic assessment:

- Clinical nurse specialist (CNS)
- Licensed independent clinical social worker (LICSW)
- Licensed marriage and family therapist (LMFT)
- Licensed professional clinical counselor (LPCC)
- Licensed psychologist (LP)
- Psychiatric nurse practitioner (NP)
- Psychiatrist

In addition, the following individuals may render a diagnostic assessment:

- An individual certified by tribal council as a mental health professional, serving a federally recognized tribe
- Mental health practitioners who qualify as clinical trainees
## Diagnostic Assessment Components

<table>
<thead>
<tr>
<th>Assessment methods</th>
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<tbody>
<tr>
<td>CASII (age 6-17), ECSII (age 0-5), SDQ (children's assessments)</td>
<td>X</td>
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<tr>
<td>LOCUS (not required at this time)</td>
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Agencies are allowed to accept external diagnostic assessments but they need to contain all of the necessary information for a functional assessment and SED designation.
The treating Mental Health Professional completes the CASII and SDQ as part of the Diagnostic Assessment. CASII and SDQ are commissioner approved screenings and assessment methods.

Mn. Rule 9505.0372, subp. 1(b)

The standard diagnostic assessment must be done within the cultural context of the client and must include relevant information about:

(5) the screenings used to determine the client's substance use, abuse, or dependency and other standardized screening instruments determined by the commissioner;

(6) assessment methods and use of standardized assessment tools by the provider as determined and periodically updated by the commissioner;
DHS Bulletin #17-53-01

CASII functions:

• Diagnostic Assessment Component
• Level of Care Screening
Diagnostic Assessment Component

The CASII or ECSII must be administered as part of the Diagnostic Assessment and Clinical Review Process.

The treating mental health professional is required to administer the CASII and the SDQ to all children receiving clinical services.

The treating mental health professional is responsible for placing the CASII an SDQ results into the CMH Outcome Measures System.

The treating mental health professional should provide case manager and all team members with a copy of the CASII and SDQ to ensure that everyone is using the same information to plan services and supports.
Remember the Mental Health Authority

DHS policy – The case manager is not responsible for completing the CASII and SDQ if it is for the purposes of eligibility. It is the responsibility of the treating mental health professional to provide the case manager with these tools.

County or MCO may require case manager to complete or contact treating MHP to access tools.
The Golden Thread

Diagnostic Assessment

Case Manager supports Child and Family

Functional Assessment

Individual and Family Community Support Plan

Transition Plan

Other assessment and plans as needed

Case Closure

Case Manager supports Child and Family

Diagnostic Assessment

Functional Assessment

Individual and Family Community Support Plan

Transition Plan

Other assessment and plans as needed

Case Closure
Review of Case Management Cycle

Assessment:
Review diagnostic assessment, review screening tools, FA, level of care, and reassessment

Working Relationship:
Person-centered & Recovery-oriented

Monitoring and Coordination:
Review of goal progress and effectiveness of services, resources, and supports

Planning:
Develop IFCSP, transition plan, and other plans as needed

Referral and Linkage:
Implement the IFCSP, acquire resources, services, and natural supports
Review of Case Management Cycle

1. ASSESSMENT
- Reason for Service Request
- Diagnostic Assessment
- Functional Assessment
- Collateral Reports
- Statement of Client Need

2. PLANNING
- Determination of strengths and service needs in each functional area
- Statement of services needed but not available
- Goals related to identified needs
- Specification of service activities, frequency of activities, and person responsible
- Description of how service effectiveness will be evaluated

3. REFERRAL
- Identification of service providers assisting client
- Record of dates when services are expected to be provided

4. MONITORING
- Evidence of progress towards goals
- Notation of significant changes in functioning or emergence of new problems/concerns
- Record of follow up activities needed to ensure client receives adequate care
## Children’s Mental Health Work Flow

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<th>Timelines</th>
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<td>Within 30 days of the first meeting with the child and at least every 180 days after the development of the ICSP</td>
<td>Mn. Stats. 245.4871, subd. 18a</td>
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<td>For children between the ages of 17 and 21 before discontinuing case management services</td>
<td>Mn. Stats. 245.4881, subd. 1</td>
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### Documentation

#### CMH-TCM Requirements

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- Establishment of eligibility
- Update Diagnostic Assessment
  - marked change in functioning
  - at least every 36 months
- Record of each face-to-face and collateral contact (e.g. progress notes)
- Documentation of supervision
- Use of electronic signatures
Consequences of Inadequate Documentation: State of Massachusetts

What is the biggest challenge or aggravation you have faced in trying to document your case work adequately?
• Benefits of sound documentation

• The Golden Thread
1. ASSESSMENT
- Reason for Service Request
- Diagnostic Assessment
- Functional Assessment
- Collateral Reports
- Statement of Client Need

2. PLANNING
- Determination of strengths and service needs in each functional area
- Statement of services needed but not available
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- Record of follow up activities needed to ensure client receives adequate care
Assessment:

Review diagnostic assessment, review screening tools, FA, level of care, and reassessment
Federal Requirements

S. 440.169 Case Management Services

• Comprehensive assessment and periodic reassessment
• Development (and periodic revision) of specific care
• Referral and related activities
• Monitoring and follow-up activities
Assessment

Mn. Stats. 245.4871, subd. 18a

Functional Assessment

Plan

Mn. Stats. 245.4871, subd. 19

Individual and Family Community Support Plan (IFCSP)
### Assessment Elements

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<tbody>
<tr>
<td>Individual Family &amp; Community Support Plan</td>
<td>- All CMH cases</td>
<td>- Within 30 days of being assigned case</td>
<td>- Found under the “Service Plans” tab under the workgroup</td>
<td>- Yes</td>
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<tr>
<td></td>
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<td>- Every 180 days thereafter</td>
<td></td>
<td>- Mn. Stats. 245.4871, subd. 19</td>
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<td>- All CMH cases</td>
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<td>- There is not a template in SSIS</td>
<td>- Yes</td>
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<tr>
<td>Transition Plan</td>
<td>- Required for kids 17 and older that are closing CMH services</td>
<td>- Within 90 days prior to case closing</td>
<td>- There is not a template for transition plans in CMH-TCM, SSIS, or MHIS</td>
<td>- Yes</td>
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<td></td>
<td>- Can be used for other kids, if useful</td>
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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;

........
Who completes the FA?

• After reviewing the Diagnostic Assessment and meeting with the child and family, the case manager completes the Functional Assessment

• FA was put in statute in 2015 – Mn. Stats. 2458.4871, Subd. 18a

Frequency

Within 30 days of the first meeting with the child and at least every 180 days after the development of the IFCSP
Required elements

- Mental health symptoms
- Use of drugs and alcohol
- Social functioning
- Self-care and independent living capacity
- Financial assistance needs
- Other needs and problems
- Mental health needs
- Vocational and educational
- Interpersonal functioning
- Medical and dental
- Housing and transportation
FUNCTIONAL ASSESSMENT

CLIENT NAME:

TIME OF FUNCTIONAL ASSESSMENT: ___Initial___ 6 mos ongoing___ discharge

FUNCTIONAL ASSESSMENT DATE:

DIAGNOSTIC ASSESSMENT DATE:

1. Mental Health Symptoms: (Consider degree of presence of depressed mood, loss of interest, suicidal ideation, isolation; anxiety; agitation, paranoid ideation, manias, sleep disturbance; thought disorder, hallucinations, loose associations. Consider the degree these issues are barriers to function and level of need for intervention.)

2. Mental Health Service Needs: (Consider sufficiency of available therapy, psychiatric care, medication education and management, the “match” between recipient needs and providers’ accessibility, willingness of recipient to use available system, degree of need for facilitation of same.)

3. Use of Drugs and Alcohol: (Consider degree of use as it affects life functioning, interference with medication or other health concerns; effect on interpersonal relationships, use of assistance to self medicate, capacity of use responsibility versus a continuum of abuse/dependence.)

4. Vocational Functioning: (Consider level of activity, focus, and accomplishment in this area as related to barriers presented by symptoms or residual effects of SMI; level of support and intervention needed to achieve gainful employment.)

5. Educational Functioning: (Consider level of activity, focus, and accomplishment in this area as related to barriers presented by symptoms or residual effects of SMI; level of support and intervention needed to achieve educational success.)

6. Social Functioning: (Consider degree of social connectedness in light of wishes for the same, degree of need for services and support to enable the recipient to function in social setting, observation of social cues permitting “usual” social interaction in community settings (i.e. church bingo movies, casual friendships, density of social network i.e. how many people are friends? Are friends connected to each other? level of reciprocity in the individual’s network i.e. does the individual help or give to others? Does the individual have a “confidante” or intimate friend?)

7. Interpersonal Functioning: (Consider capacity to engage and maintain family relationships, including managing expectations for parenting, if relevant and other reciprocal tasks, degree of satisfaction with current level of family and friendship connections, degree to which recipient needs assistance and support to function in this area.)

8. Self Care/Independent Living Capacity: (Consider capacity to manage grooming, nutrition needs, housekeeping skills for current housing, and activities of daily living in the context of the person’s current living arrangement, or in the context of needs for assistance to attain a higher level of independence.)

9. Medical Health: (Consider current health status, self awareness of current health status, and capacity to make responsible health care decisions and to follow up with appropriate care, need for assistance to negotiate health care system.)

10. Dental Health: (Consider current dental health status, self awareness of current dental health status, capacity to make responsible dental health care decision and to follow up with appropriate care, need for assistance to negotiate dental health care system.)

11. Obtain/Maintain Financial Assistance: (Consider capacity to manage personal finances, capacity to understand and comply with needed paperwork requirements to obtain and maintain financial assistance; capacity to manage appropriate reporting of income and use of $SS work incentive program, MAEPD, and other program to maintain financial stability during rehabilitation efforts.)

12. Obtain/Maintain Housing: (Consider capacity to handle landlords or public housing bureaucracy, if living independently, ability to negotiate social service system to obtain housing with supports, board and lodges, etc; capacity of appropriate community behavior in these settings with neighbors or housemates; assess needs for assistance in current setting or to attain greater independence, living in a shelter or homelessness.)

13. Transportation: (Consider capacity to use public or private transportation as it relates to the effects of SMI or TBI and capacity to secure transportation in their circumstances; degree of assistance needed to either obtain or use transportation.)

14. Other: (Consider legal status issues, culture, religion, risk and safety, immigrant, tribal, language, sexual orientation, gender issues, parenting.)
• Content gaps
• Lack of context
• Insufficient attention to strengths and wellness
• Finding the “sparks” (the good, beautiful, useful)

• 40 Developmental Assets Surveys

www.search-institute.org
"Please turn it down - Daddy's trying to do your homework."
• American children averaging 52 hours per week in front of a screen

• Screen time linked to attention problems, obesity, and aggression

• Kids and mobile electronic devices

• Effects of parents’ use of technology
Invisible family rules

- Coalitions
- Boundaries
- Power hierarchies
• Obtain and review relevant records
• Narrative approach
• Assess barriers to attendance
• Extra-curricular involvement or interest
• Ensure parents have adequate information about special education
**Definition:** When someone with more power unfairly hurts someone with less power over and over again. The impact of the mistreatment is often deeply felt and long-lasting.

**Problem:** Approximately 160,000 children do not go to school each day for fear of being bullied

**Types**

- physical
- social
- emotional
- virtual
Warning Signs of Bullying

• Avoidance of school, school-related events
• Reluctance to walk to or from school
• Unexplainable drop in academic performance
• Physical complaints
• Changes in sleep patterns, nightmares
What to Do About Bullying

• Take behavior/concerns seriously

• Be careful not to over- or underreact

• Listen, collect information (try to understand problem from child’s perspective)

• Involve family and school in finding solutions
Clinically significant chemical use can be gauged by the following indicators:

• Failure to perform major role obligations of home, school, or work
• Needing more of substance to achieve effects
• Unsuccessful efforts to quit
• Using more of substance than intended
• Significant others concerned
• Continued use in spite of negative consequences
• Great deal of time spent to obtain substance, use substance, or recover from its effects
• Use “BACO” to identify signs and symptoms of chemical use
  • Behavior
  • Conduct
  • Appearance
  • Odor
• Psychological vs. physical dependence
• Family context
• Cultural perspective
Interviewing Approach

• “Tell us the last time you used the following...”

• “It’s not unusual for someone your age to know about or have tried chemicals. Let’s start with tobacco...”
Vulnerability of children to alcohol

• Under-sensitive to warning sign of intoxication
• Over-sensitive to damaging effects on brain

Perceptions of harm and acceptability

• Kids viewing chemicals as safe and socially acceptable are more likely to use
• Vaping?
Components of Independent Living Assessment (handout)

- Educational/vocational
- Health care
- Transportation
- Money management
- Planning for housing
- Social and recreational
- Family and community connections

The Ansell-Casey Life Skills Assessment is a free tool that can be accessed online: www.caseylifeskills.org
Case Manager’s role in health promotion

• Not a doctor of medicine

• Health does play an important role in overall wellness

• Families need assistance in navigating the insurance system

• A CM can provide assistance in identifying resources that lower health care costs and emergency room usage
Contact Information: (client name, address, family, case manager, home clinic)

Significant Conditions:

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>Provider Seen</th>
<th>Recommendations &amp; Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications Prescribed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tests &amp; Screenings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Health Promotion

• Interplay between medical and mental health symptoms
Planning:
Develop IFCSP, transition plan, and other plans as needed
**Goal:** Understand the roles of the case manager, child, family, family’s informal support network, and other service providers in designing and implementing the Individual Family Community Support Plan

**Objectives:**

a) Describe how IFCSPs and other plans (e.g. Individualized Education Programs and Out-of-Home Placement Plans) can be coordinated

b) Identify the types of goals that are appropriate for IFCSPs
Mn. Stats. 245.4871, subd. 19
Mn. Rule 9520.0902, Subp 22

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;

............
Who completes the IFCSP?

After reviewing the Diagnostic assessment, FA, and meeting the child and family, the CMH TCM completes the IFCSP.

Frequency

Within 30 days of the first meeting with the child and at least every 180 days after the development of the ICSP
• treat the symptoms and dysfunctions determined in the DA
• improve family functioning
• improve functioning in education and recreation settings
• enhance vocational development
• enhance daily living skills
• relieve conditions leading to emotional disturbance and improve the personal wellbeing of the child
• improve interpersonal and family relationships
• assist in obtaining transportation, housing, health services, and employment
What do you consider to be the characteristics of a strong case plan (e.g., IFCSP)?
Examples

- handouts

- Anoka & Hennepin Counties
IFCSP
SMART Goals

• Specific
• Measurable
• Agreed-Upon
• Realistic
• Time-Dated
Problem: Mary is cutting when she is angry and at home alone.

• Goal (broad terms): Mary will remain safe at home

• Objective (narrow, measurable, observable): Mary will not cut at home in the next 30 days

• Strategies (how and who): Mary will calm self using breathing exercise taught by therapist

• Date of Review: within 30 days
Goal Writing Practice

1. Mary failing in school
2. Mary not attending to personal hygiene
3. Mary refusing to go to bed at night
• IFCSP vs. Out-of-Home Placement Plan
• IFCSP vs. Individual Treatment Plan
• IFCSP vs. Individualized Education Program
• IFCSP vs. Transition Plan
## FA/IFCSP Crosswalk

### FA/IFCSP Common Required Elements

<table>
<thead>
<tr>
<th>FA</th>
<th>IFCSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health symptoms</td>
<td>treat the symptoms and dysfunctions determined in the diagnostic assessment</td>
</tr>
<tr>
<td>Mental health needs</td>
<td>relieve conditions leading to emotional disturbance and improve the personal well-being of the child</td>
</tr>
<tr>
<td>Use of drugs and alcohol</td>
<td></td>
</tr>
<tr>
<td>Vocational and educational</td>
<td>improve functioning in education and recreation settings</td>
</tr>
<tr>
<td>Social functioning</td>
<td>improve interpersonal and family relationships;</td>
</tr>
<tr>
<td></td>
<td>Improve family functioning</td>
</tr>
</tbody>
</table>
### FA/IFCSP Common Required Elements

<table>
<thead>
<tr>
<th>FA</th>
<th>IFCSP</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Use of drugs and alcohol</td>
<td></td>
</tr>
<tr>
<td>Vocational and educational</td>
<td>improve functioning in education and recreation settings</td>
</tr>
<tr>
<td>Social functioning</td>
<td>improve interpersonal and family relationships/improve family functioning</td>
</tr>
<tr>
<td>Interpersonal functioning</td>
<td>improve interpersonal and family relationships/improve family functioning</td>
</tr>
<tr>
<td>Self-care and independent living</td>
<td>enhance daily living skills</td>
</tr>
<tr>
<td>Medical and dental health</td>
<td>assist in obtaining transportation, housing, <strong>health services</strong>, and employment</td>
</tr>
<tr>
<td>Financial assistance needs</td>
<td></td>
</tr>
<tr>
<td>Housing and transportation</td>
<td>assist in obtaining transportation, housing, health services, and employment</td>
</tr>
<tr>
<td>Other needs and problems</td>
<td>enhance vocational development</td>
</tr>
</tbody>
</table>
Planning:
Develop IFCSP, transition plan, and other plans as needed
Mn. Stats. 245.4881, subd. 1

..... Before discontinuing case management services under this subdivision for children between the ages of 17 and 21, a transition plan must be developed. The transition plan must be developed with the child and, with the consent of a child age 18 or over, the child's parent, guardian, or legal representative. The transition plan should include plans for health insurance, housing, education, employment, and treatment.....
Transition Plan

Who does it?

Before discontinuing services with a youth of transition age, the CMH TCM case manager completes the Transition Plan.

When?

For youth between the ages of 17 and 21 before discontinuing case management services.
Transition Plan

Required Elements

• Health insurance
• Housing
• Education
• Employment
• Treatment
Individual and Family Community Support Plan (IFCSP)
Out of Home Placement Plan (OHPP)
Plans Related to Out-of-Home Placement

- County Placement Authority
  - Non-MA funded
  - CMH – MH services & needs
  - CW – Foster Care placement requirements
Counties and some contract agencies have placement authority

Child Welfare is policy area supervising placement and placement plans

Children’s Mental Health assesses and coordinates needs and services
To Make Your Life Easier: The Change

Individual and Family Community Support Plan (IFCSP)

PLUS

Out of Home Placement Plan (OHPP)
Targeted Case Management


Consult with the Minnesota Department of Human Services, Children’s Mental Health staff regarding how this plan may relate to mental health targeted case management. The Out-of-home Placement Plan may be the identified plan for mental health targeted case management.
# Out of home Placement Plan requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Responsible Party</th>
<th>Timelines</th>
<th>Legal Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Home Placement Plan</td>
<td>Case Manager (Child Welfare and Children’s Mental Health)</td>
<td>*Prepared with the parent within 30 days of foster care placement. Completed in consultation with the child’s GAL, child’s tribe (if an Indian Child), foster parents or representative of the facility, and child when appropriate. *Plan is updated when the child changes placement settings or every 180 days.</td>
<td>Minnesota Statutes, section 260C.212, <em>subd 1</em></td>
</tr>
<tr>
<td>Monthly case worker visits</td>
<td></td>
<td>*Every child in foster care shall be visited monthly by the case manager. The majority of the visits occur in the child residence. The case manager is the person responsible for managing the child’s foster care placement as assigned by the county or tribal agency.</td>
<td>MN statues, section 260C.215, <em>subd 4a</em></td>
</tr>
</tbody>
</table>
Mn. Stats. 245.4871

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
Inserting IFCSP elements into the OHPP

<table>
<thead>
<tr>
<th>Areas where required IFCSP services can be entered</th>
<th>IFCSP Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services noted in OHPP</strong></td>
<td><strong>IFCSP Elements</strong></td>
</tr>
<tr>
<td><strong>Access treatment and services details</strong> (box 1)</td>
<td>Symptoms and dysfunctions determined by DA</td>
</tr>
<tr>
<td>Reference the Diagnostic Assessment and the diagnosis that enables the child to be eligible for SED designation.</td>
<td></td>
</tr>
<tr>
<td><strong>Access treatment and services details</strong> (boxes 2&amp;3)</td>
<td>Relieve conditions leading to emotional disturbance and improve the personal well-being of the child</td>
</tr>
<tr>
<td>Describe how service pertains to/assists in meeting the child’s mental health needs. Indicate frequency.</td>
<td></td>
</tr>
<tr>
<td><strong>Medical needs</strong> (box 5)</td>
<td>Assist in obtaining Health services</td>
</tr>
<tr>
<td>Describe how the caretaker meets the child’s/youth’s physical and mental health needs.</td>
<td></td>
</tr>
<tr>
<td><strong>Educational needs</strong> (box 3)</td>
<td>Improve functioning in education</td>
</tr>
<tr>
<td>Describe and identify specific services needed by a child to improve their academic and career educational functioning OR</td>
<td>Enhance vocational development</td>
</tr>
<tr>
<td>Services – Check Vocational/educational services.</td>
<td></td>
</tr>
<tr>
<td>Developmental needs (box 2) Describe and identify specific services needed by a child to enhance their daily living skills OR Services – Check Independent living services.</td>
<td>Enhance daily living skills</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Interests and talents – (box 2) Describe and identify specific services needed by a child to improve functioning in recreational settings OR Services – Check Recreational services</td>
<td>Improve functioning in recreational settings</td>
</tr>
<tr>
<td>Preserving relationships needs (box 3) Describes and identify specific services needed by a child to improve interpersonal and family relationships OR Services - Other</td>
<td>Improve interpersonal and family relationships Improve family functioning</td>
</tr>
<tr>
<td>Services - Other</td>
<td>Assist in obtaining transportation</td>
</tr>
<tr>
<td>Services - Other</td>
<td>Assist in obtaining Housing</td>
</tr>
<tr>
<td>Services - Other</td>
<td>Assist in obtaining employment</td>
</tr>
</tbody>
</table>
### Minnesota Department of Human Services

#### Out of Home Placement Plan

Voluntary Foster Care for Treatment

(CW-TCM Plan)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan Start Date:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ / /</td>
<td>/ / /</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICWA:</th>
<th>Plan Will Be Reviewed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ / /</td>
</tr>
</tbody>
</table>

Voluntary Placement Agreement was signed: ___/___/____

Independent Living Plan is completed and attached for foster youth age 14 and older. □ Yes □ No □ NA
Inserting IFCSP elements into the OHPP

<table>
<thead>
<tr>
<th>Access treatment and services details (box 1)</th>
<th>Symptoms and dysfunctions determined by DA</th>
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<tr>
<td>Reference the Diagnostic Assessment and the diagnosis that enables the child to be eligible for SED designation.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Access treatment and services details (boxes 2&amp;3)</th>
<th>Relieve conditions leading to emotional disturbance and improve the personal well-being of the child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe how service pertains to/assists in meeting the child’s mental health needs. Indicate frequency.</td>
<td></td>
</tr>
</tbody>
</table>
Access Treatment and Services Details

Describe how it was determined that the child needs treatment including screening teams and levels of care determination:

How will the treatment services reduce the symptoms and/or improve the child’s functioning at home or in the community?

What are the treatment services, including the time frame?
### Medical needs (box 5)
Describe how the caretaker meets the child’s/youth’s physical and mental health needs.

**OR**

**Services — Other - Indicate service type**

**Assist in obtaining Health services**
Medical Needs

To meet the child’s/youth’s current medical needs, the caregiver:

☐ Ensures that the child gets routine medical and dental care, including immunizations
☐ Adapts their home for a child’s medical needs
☐ Ensures that the child receives the specialized medical or dental care required to address the child’s health condition
☐ Ensures that the child receives mental health services to meet identified needs

Specifically describe how the caregiver meets the child’s/youth’s physical and mental health needs:
<table>
<thead>
<tr>
<th><strong>Educational needs</strong> (box 3)</th>
<th><strong>Improve functioning in education</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe and identify specific</td>
<td>Enhance vocational development</td>
</tr>
<tr>
<td>services needed by a child to</td>
<td></td>
</tr>
<tr>
<td>improve their academic and career</td>
<td></td>
</tr>
<tr>
<td>educational functioning</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td><strong>Services</strong> – Check</td>
<td></td>
</tr>
<tr>
<td>Vocational/educational services.</td>
<td></td>
</tr>
</tbody>
</table>
Educational Needs

To meet the child’s/youth’s educational needs, the caregiver:

☐ Actively participates in the child’s routine education, including communicating with school, assisting with homework, and attending parent-teacher conferences as needed
☐ Supports the child’s special educational needs, including participating in planning meetings to assess and review the child’s special educational goals
☐ Supports the youth’s post-secondary education needs, including assisting as needed with tasks such as arranging transportation, applying for financial aid and filling out post-secondary applications

Specifically describe the educational supports provided by the caregiver that meets the child’s/youth’s individual education needs:
<table>
<thead>
<tr>
<th><strong>Developmental needs</strong> (box 2)</th>
<th>Enhance daily living skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe and identify specific services needed by a child to enhance their daily living skills</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td><strong>Services</strong> – Check Independent living services.</td>
<td></td>
</tr>
</tbody>
</table>
Developmental Needs

To meet the child’s/youth’s current developmental needs, the caretaker:

☐ Accepts-addresses the child’s developmental delays
☐ Provides care and a home environment that is age and developmentally appropriate to promote healthy child development and growth
☐ Assists youth to develop independent living skills at home and in the community

Specifically describe how the caregiver promotes the child’s/youth’s development in the home or facility:
<table>
<thead>
<tr>
<th><strong>Interests and talents - (box 3)</strong></th>
<th>Improve functioning in recreational settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe and identify specific</td>
<td></td>
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<tr>
<td>services needed by a child to</td>
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<td>improve functioning in</td>
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<tr>
<td>recreational settings</td>
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</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td><strong>Services</strong> - Check Recreational</td>
<td></td>
</tr>
<tr>
<td>services</td>
<td></td>
</tr>
</tbody>
</table>
Inserting IFCSP elements into the OHPP

Interests and Talents

To continue and encourage the child’s/youth’s interests and talents, the caregiver:

- Supports the development of the child’s interests and talents
- Applies the Reasonable and Prudent Parent Standard to permit the child’s/youth’s participation in extracurricular, social, community and cultural activities typical for the child’s age and are developmentally appropriate

Specifically describe how the caregiver supports age appropriate activities that meet child’s/youth’s interests, builds skills, and highlights talents:
| Preserving relationships needs (box 2) | Improve interpersonal and family relationships
Improve family functioning |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes and identify specific services needed by a child to improve interpersonal and family relationships OR Services - Other</td>
<td></td>
</tr>
</tbody>
</table>

Inserting IFCSP elements into the OHPP
Preserving Relationships

To preserve the child’s relationships to current caretakers, parents, siblings and relatives, the caregiver:

☐ Lives in close proximity to the child’s reunification home
☐ Is willing to mentor the child’s parents to support reunification
☐ Is willing to help with visitation to preserve relationships
☐ Is willing to care for the child and his/her siblings
☐ Is open to contact with birth family and other people important to the child

Specifically describe how the provider supports contact with the birth family and other people important to the child/youth:
## Inserting IFCSP elements into the OHPP

<table>
<thead>
<tr>
<th>Services - Other</th>
<th>Assist in obtaining transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services - Other</td>
<td>Assist in obtaining Housing</td>
</tr>
<tr>
<td>Services - Other</td>
<td>Assist in obtaining employment</td>
</tr>
</tbody>
</table>
## Services

List the services for the child/youth and identify the provider of the services:
(Select as many as apply)

<table>
<thead>
<tr>
<th>Services</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency visits child monthly</td>
<td></td>
</tr>
<tr>
<td>Child development assessment</td>
<td></td>
</tr>
<tr>
<td>Child development services</td>
<td></td>
</tr>
<tr>
<td>Developmental disabilities case management services</td>
<td></td>
</tr>
<tr>
<td>Waiver services</td>
<td></td>
</tr>
<tr>
<td>Child mental health assessment</td>
<td></td>
</tr>
<tr>
<td>Child mental health case management services</td>
<td></td>
</tr>
<tr>
<td>Counseling/Therapy</td>
<td></td>
</tr>
<tr>
<td>Child care services</td>
<td></td>
</tr>
</tbody>
</table>
# Inserting IFCSP elements into the OHPP

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical health assessment</td>
<td></td>
</tr>
<tr>
<td>Chemical health services</td>
<td></td>
</tr>
<tr>
<td>Family Group Decision Making</td>
<td></td>
</tr>
<tr>
<td>Employment services</td>
<td></td>
</tr>
<tr>
<td>Vocational training/educational services</td>
<td></td>
</tr>
<tr>
<td>Independent living services</td>
<td></td>
</tr>
<tr>
<td>Recreational services</td>
<td></td>
</tr>
<tr>
<td>Other Services Provided</td>
<td></td>
</tr>
</tbody>
</table>
The insertion of the IFCSP elements into the OHPP is DHS policy as determined by DHS Child Welfare and DHS Children’s Mental Health.

Be mindful your county, tribe or managed care organization may have differing policies.

Please consult with the supervisor of our organization or, if applicable, your MCO. Should those policies differ from this DHS advisement, please adhere to those policies.
# Managed Care Organizations vs. Fee for Service

 Managed care vs fee for service file requirements

<table>
<thead>
<tr>
<th>Managed care</th>
<th>Fee for service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decisions congruent with state law and rule</td>
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</tr>
<tr>
<td>Based on medical necessity (DA)</td>
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</tr>
<tr>
<td>Check your managed care contract (enhanced on the MCO side)</td>
<td>Basic policy structure</td>
</tr>
<tr>
<td>Prevention of fraud</td>
<td>Prevention of fraud</td>
</tr>
</tbody>
</table>

- MCO’s are held accountable to ensure the person receives accessible, timely, and quality services
Referral and Linkage:

Implement the IFCSP, acquire resources, services, and natural supports
Referral and Linkage

**Goal:** Appreciate the wide range of resources and services available to support clients.

**Objectives:**

a) Identify mental health informational and advocacy resources that are available to all state residents.

b) Demonstrate awareness of resources, programs, and services within one’s particular region of the state.

c) Define strategies for helping clients maintain health care coverage and managing county-to-county transfers of case responsibility.
What are the most difficult referrals for you to complete?

What strategies have you adopted to ensure clients follow through on referrals?
Monitoring and Coordination:

Review of goal progress and effectiveness of services, resources, and supports
**Goal:** Monitor and document the effectiveness and the appropriateness of services received by clients.

**Objectives:**

a) Demonstrate the ability to compose concise and specific progress notes.

b) Identify available monitoring tools.
What would you consider to be the basic requirements of a case note?
• Core elements of MH TCM progress notes

• Progress note formats
  • SOAP (symptoms, observations, assessment, plan)
  • DAP (diagnosis, assessment, plan)
  • Scott County example

• Common progress note mistakes
• CASII and SDQ
• Parent and teacher rating scales (CBCL & BASC)
• Educational and clinical records
• Self-Navigation Skills Assessment (handout)
Thank you!