Exhibit AP

Mental Health Case Management Standards

A. Definitions:

The definitions below are for the purposes of this Exhibit. Other definitions may exist in care coordination or other authorities.

"Caseload" means those clients which are managed by a designated case manager.

"Case management services consist of activities that identify the recipient's needs, plan services, link the service system with the person, coordinate the various system components, monitor service delivery, and evaluate the effect of the services received. This covered service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service." Rule 65E-14.021(4)(c)1.

"Service Plan" is the part of the clinical record which outlines a comprehensive strategy for improving a client's quality of the services and resources necessary to achieve these goals and objectives. The service plan is designed to integrate the efforts and effects of multiple service and resource providers. The case manager and the client develop the service plan in conjunction with family members, service providers and other entities and individuals necessary to its implementation.

Treatment Plan: is an individual document or identifiable section of the service plan developed by treatment staff and the client which depicts goals or objectives for the provision of services within specific treatment environments. Examples of treatment environments include, but are not limited to, day treatment, vocational, residential, outpatient and activities of daily living programs.

B. Overall Goal of Case Management.

The primary goal of care management is to optimize the functioning of individuals who have complex needs by coordinating the provision of quality treatment and support services in the most efficient and effective manner. The desired outcomes for persons using the service system are self-sufficiency and satisfaction in the living, learning, work and social environments of their choice.

Case managers shall have at a minimum a bachelor's degree with major course work in a human services field or equivalent training and experience on a year for year basis in a related field. (

(1) Case management responsibilities include, but are not limited to, the following activities:

(a) Development and implementation of a case management assessment:

1. A case management assessment is a holistic review of a client's living situation which includes a determination of the client's strengths and weaknesses, the client's needs and resources, and the strengths and weaknesses of the client's support system. The case managers shall be responsible for the overall completion of the assessment, but shall work with the client and consult with relevant professionals where specific expertise is needed.

2. The case management assessment shall consider information from the following sources:

a. Client's assessment of his or her personal situation;

b. Input from the family, friends or significant others. Such input shall be sought with the consent of the client;

c. Collateral information which may include records dealing with previous psychiatric hospitalizations, outpatient treatment and evaluations, summaries and progress notes from other involved human service individuals or agencies. If collateral information is not available, this shall be documented in the case record;
d. Information from the referral source;
e. Pertinent service agencies with whom the client is involved and an evaluation of the impact these services have on the client's life.

3. The case management assessment shall consider the following:
a. The presenting problem;
b. Client's current and potential strengths and deficits;
c. The family's current and potential strengths and deficits;
d. Client's relationship with family members and significant others;
e. The impact of the currently provided services on the client's life;
f. Client's involvement or need for involvement in client support groups or ancillary social support systems;
g. Need for training in community living skills, medications, or activities of daily living;
h. Need for education, vocational training or job-seeking skills;
i. Need for housing, food, clothing, and transportation;
j. Need for mental health, alcohol and drug abuse services;
k. Need for medical and dental services, including current medications;
l. Need for legal services;
m. Need for backup support and consultation to family, friends, landlords, employers, community agencies and community members who come in contact with the client; and
n. Need for and the establishment of financial resources such as Social Security, Supplemental Security Income, Veterans Administration or trust funds.

4. The case management assessment is to consist of a single identifiable, dated document, included in the clinical record.

5. The initial case management assessment must be completed within 30 days of the referral of the client for case management services.

6. A home visit is to be made prior to the completion of the Assessment, unless the case manager's supervisor deems such a visit unsafe to the case manager or such a visit is denied by the client.

In such instances where a home visit does not occur:
a. The reasons for the failure to make such a visit will be documented in the case record and signed by the case manager and the case manager supervisor.
b. Subsequent visitations and the suitability of the housing shall be considerations addressed in the service plan.

7. Subsequent written case management assessments shall be completed and an updated Service Plan developed at a minimum of every 6 months, or when the client changes residence, enters or is discharged from a state treatment facility or at other times when the client's situation changes significantly.

(b) Service Planning

1. Service planning is the process of developing a general strategy to utilize strengths and address weaknesses identified through case monitoring and through assessments. The case manager, in conjunction with the client, shall be responsible for the development of the service plan. However, service planning is a collaborative effort which also involves family members, service providers, or others significant to the implementation of the resultant plan. The results of the service planning process shall be a service plan.

2. The Service Plan must be on a single identifiable and dated document, developed within 15 days of a completed Assessment and signed by the client, case manager, the case manager's supervisor, and other appropriate participants involved in the service plan development.

   The service plan is an individualized document which meets the comprehensive needs of the client. All service plans shall be included in the client's record.

3. In cases where immediate services are needed, service delivery shall not be delayed pending completion of either the assessment or service plan.

4. The Service Plan shall contain a description of the long-term desired outcome for the case.

5. The Service Plan shall contain measurable goals and objectives derived from the assessment of client's strengths, deficits and resource needs.
   a. Each objective must have an identified time frame for achievement, and stated in terms of observable and measurable outcomes.

   b. Each objective shall state the name of the individual or agency responsible for the action to be achieved.
6. The client shall be provided a copy of the Service Plan, and this shall be documented in the record. With the approval of the client, others involved in its development or implementation shall be provided with a copy of the service plan.

(c) Linkage and Brokerage

The case manager shall ensure that the Service Plan is implemented through a variety of linkage and brokerage activities designed to procure specified services, treatment and resources for the client.

1. Such activities include verbal or written referrals, telephone calls, meetings, assistance with making appointments and completing applications, assistance at interviews and hearings, transportation and supportive counseling.
2. The case manager shall convene case staffing at major decision points during the client's involvement with the alcohol, drug abuse and mental health system. Such decision points shall include movements to a lesser or more restrictive environment in the community or transfers to and from state hospitals. Such conferences shall be attended, as appropriate, by the client, family members, service providers and significant others.

(d) Monitoring

Case Managers shall ensure that Service Plan goals and objectives are consistently pursued, assess the functioning level of the client, and assess progress toward the achievement of goals and objectives

through a range of monitoring activities including telephone calls, home visits, case and treatment reviews, interviews and site visits.

1. Where monitoring reveals that minor adjustments are necessary in order to better accomplish the goals and objectives of the service plan, the case manager shall update these portions of the plan and take action to implement these adjustments.
2. Where monitoring reveals that conditions have changed to the extent that the service plan is no longer valid, the case manager shall make a reassessment and ensure the development of a new service plan.

(e) Advocacy

1. Case managers shall function in the best interest of the client and shall intercede on behalf of the client to assure that service and resources needs are met.
2. The case manager shall identify service and resource gaps and barriers which limit a client's access to existing services and resources to client managers.

(2) The case manager shall make a minimum of a monthly face-to-face contact with all clients residing in the community.

(3) Case managers may utilize contingency funds provided by the department in accordance with circuit procedures. These shall be used to provide for unmet resource needs of clients when other resources are not available or in combination with other resources.

(4) For clients residing in the community, the case manager shall make a home visit or field visit within the client's natural environment at a minimum of every other month, unless the case manager's supervisor deems such visits unsafe to the case manager or the client declines such visitation during the planning process. In such instances where home visits are not to occur:

(a) The reason for the failure to make such a visit will be documented in the case record signed by the case manager and case manager supervisor,

(b) Subsequent visitations and the suitability of the housing shall be considerations in the service plan.

(5) When a client misses an appointment related to the service plan or is absent from a treatment program without notification, the case manager shall attempt to contact the client either by telephone or face-to-face meeting within twenty-four hours. If initial attempts to contact the client are unsuccessful, the case manager shall make additional efforts by telephone, face-to-face meetings, or correspondence. Upon contacting the client, the case manager shall explore the reasons for the absence or the missed appointment and shall work with the client to resolve any issues inhibiting the effective implementation of the plan. Such efforts and their results shall be documented in the case record.

(6) Case Management Record.

1. An individualized case record for each client shall be maintained.
2. A clearly identifiable portion of the agency's record shall be devoted to case management. This portion shall contain the demographic information and items specified in subsection 65E-4.014(3)b., F.A.C.
3. The case record shall be maintained in accordance with Rule 65E-4.014, F.A.C.
4. In addition to items specified in Rule 65E-4.014, F.A.C., the record shall contain:
   (a) The name of the current assigned case manager

(b) Any copies of a consent to give information relevant to the case.
(c) Assessment information as stated above.
(d) Service Plan as stated above.
(e) Progress Notes, documenting all of the case manager's activities, contacts and communications on behalf of the client, including the following:
  1. Date
  2. Type of contact; for example, home visit, telephone, office visit
  3. Contacting person
  4. Person or agency contacted
  5. Brief account of contact
  6. Relevance to the Service Plan
  7. Documentation of missed appointments, follow-up, and an explanation of why the appointments were missed
  8. Documentation for the need and lack of availability of any goods or services for which contingency funds are requested
(f) Advocacy efforts as specified above.

(7) Case load. The mental health case manager's caseload shall not exceed 40 consumers at any given time.

(8) Case managers shall a minimum of a bachelor's degree with major course work in a human services field or equivalent training and experience on a year for year basis in a related field.