DEPARTMENT OF HUMAN SERVICES

Mental Health Uniform Service Standards (USS)

Project Summary with detail on mental health professional definitions.

Background

The Mental Health Uniform Service Standards project is a multi-phase reform of the regulatory structure and service standards for Minnesota's mental health care system.

Why do we need USS?

Minnesotans can take pride in our long history of establishing an innovative range of community-based mental health care services. Our mental health care system includes services ranging from school-linked mental health care that helps children build resiliency and develop the skills they need to intensive residential treatment that can help individuals avoid hospitalization or transition back into the community.

As we innovated over time, the standards that guide our range of mental health care services have become increasingly complex. Our current mental health care service standards are located in various statutes, rules and other authorities, some dating to the 1950s. Even a diligent provider can find themselves out of compliance with this web of laws, potentially facing denied claims or other challenges.

It's time that we take responsible steps to manage and support our mental health care system in a way that makes it easier for Minnesotans to receive the high quality mental health care services we need, when we need them. Passing the USS proposal this session is critical to making sure that we are managing our state's resources wisely and getting the best outcomes for our investments.

USS aligns standards to reduce administrative burden

When standards are clear and consistent, providers can spend more time delivering their full range of services and less time at their desks navigating confusing and ambiguous compliance requirements.

The USS proposal aligns the basic standards across the range of mental health care services by creating a common "core" of standards. This core includes uniform standards for:

- Policies and procedures
- Provider qualifications, scopes of practice
- Staff training
- Staff supervision
- Personnel files
- Documentation
- Client files
- Assessment and treatment planning
- Health services and medications
- Client rights and protections

In all those areas, providers will have greater continuity and ease of understanding. Beyond that, USS proposes several significant improvements and reductions in the burden of paperwork:

- Flexibility for a parent to approve their child's treatment plan via a phone call
- More time between treatment plan renewals for some services, better reflecting client pace of change
- Eliminating requirements that don't consistently help treatment planning, including the Strengths and Difficulties Questionnaire (SDQ) for children and the interpretive summary in adult rehabilitative services

USS refocuses standards on supporting quality services

The USS proposal will:

- Give providers more flexibility to build trust and understanding with the client or their family during initial assessment and treatment planning
- Provide supervisors with additional time to work with staff on refining treatment documents to support the workforce and improve outcomes
- Refocus the approval of treatment documents from quickly getting physical signatures to meaningful engagement in person-centered treatment planning

When service standards allow mental health providers the necessary time and flexibility to bring their own approaches to building rapport and use their clinical judgement, they can focus on developing trusting therapeutic relationships and delivering high quality services.

USS builds accountability where it matters

The current regulatory structure of our mental health care system is inefficient. For example, different areas of DHS — such as provider enrollment, behavioral health and licensing — may conduct similar reviews of the same program at different times, leading to significant costs and confusion for the agency and for providers.

The USS proposal begins to transition the regulatory structure of our mental health care system to a unified licensing structure. A unified licensing structure will:

- Improve accountability of the agency and providers
- Ensure greater consistency in the guidance given to providers
- Centralize reporting and investigations of complaints, including abuse, neglect, and maltreatment
- Provide the enforcement tools necessary to protect Minnesotans.

USS reflects 2.5 years of community-driven reform

The USS project was established in response to concerns from several high quality mental health providers about the complexity of our current mental health care service standards. This year's USS proposal is reflective of over 2.5 years of conversations and collaboration among a broad group of representatives of DHS, counties, Tribes, providers, and other advocacy organizations.

2017	DHS completed a set of stakeholder interviews and began early planning work.
2018	DHS had convened several stakeholder conversations, and begun documenting complexities within the current state and drafting language to begin aligning standards among different types of mental health services. A small group of involved stakeholders met regularly to inform the work, and provide feedback on the feasibility of initial language drafts. In December, DHS held a public webinar to review the USS project and review the USS language that would be included in the Governor's proposed budget. The entire scope of the USS work would not be ready, but we referred to the portions that were moving forward in the Governor's budget as "Phase 1".
2019	USS Phase 1 language was included in the Governor's proposed budget, and in the House HHS omnibus bill. While discussed significantly, it was not passed into law. The most developed form of this language can be found in HF2414, Article 7. (While the Phase 1.5 proposal draws upon this Phase 1 language significantly, some pieces have been reworked or improved.) In May, DHS sent out an invitation to participate in a formal stakeholder process. Balancing for a mix of provider types and sizes, regional

	representation, and participation from underserved communities, DHS selected applicants and formed the Phase 1.5 Design Team. From June to December, the Design Team met monthly. We began with initial conversations about priorities for certified mental health clinics, intensive residential treatment services, and the core language applicable to all programs. DHS staff followed up on comments and questions with research and analysis. The group selected priorities for more significant development, and progressively guided the work. Agendas and minutes from Design Team meetings are available here.
2020	In February, DHS presented a public webinar to review the language that was anticipated to be proposed in the 2020 legislative session, and to answer questions from the community. Due to the priority for COVID-19 response, work on USS was delayed.
2021	Throughout the 2021 legislative session, DHS will continue to work with stakeholders to clarify and improve language where needed. In the late spring, expect to see announcements about the next phase of work. This will include opportunities to be involved in future Design Teams.

Detail on 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. Minnesota's Boards of Practice are the authorities for who is a currently licensed psychologist, or which nurses are allowed to prescribe psychiatric medications. However, as a collective term, "mental health professional" includes multiple disciplines and is primarily defined by various areas of Minnesota statute, including the mental health acts and Medicaid services. A mental health professional is primarily distinguished by the ability to perform diagnostic assessment and provide psychotherapy with an independent scope of practice. Clinical trainees can perform many of the same services, but require the supervision of a mental health professional.

Statute or Authority	Notes on the definition
Rule 47 9505.0371, subp 5.	Outdated on psychology and 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" who do not share the same scope of practice. Most Medicaid services use a definition that excludes 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" who do not share the same scope of practice. Most Medicaid services use a definition that excludes allied fields.
62A.152	Refers to MH Acts, clauses (1-5), but omits 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.
Rule 9505.0260	Refers to 9505.0175, adds LMFT back in, omits LPCC

Because each of the subsequent definitions refers back to one of the unique definitions above, they also end up repeating the errors or omissions described.

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.
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.
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.