Alameda County Behavioral Health (ACBH)
Clinical Documentation Training: Module 2 – Treatment Plans

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Introduction to Client Plans

- Client Plans are plans for the provision of mental health services to clients who meet medical necessity.
- They are an outline of the goals and objectives of treatment aimed to reduce functional impairments caused by the symptoms/behaviors of a client's diagnosis.
- The mental health services identified within the plan must address identified mental health needs, consistent with the diagnosis, that are the focus of the mental health treatment.
- The plan itself acts as a progress report of the client's measure of medical necessity for services as part of the golden thread.

Scope of Practice for Client Plans

- All staff with appropriate training and experience may complete the Client Plan.

- Trainee, Mental Health Rehabilitation Specialist (MHRS) & Adjunct Staff require co-signatures by a Licensed LPHA. (Physician, Psychologist, LCSW, LMFT, RN, NP, and clinical nurse specialists, and a Waivered / Registered Professional when supervised by a licensed mental health professional in accordance with laws and regulations governing the registration or waiver.)

- If a medical provider prescribes to the client, it is best practice to obtain their co-signature.

- Clinical pharmacists may not sign the Client Plan without a co-signature by a Licensed LPHA (non-pharmacist).

The Foundation Before Writing The Client Plan

- Established medical necessity
- Completed CANS/ANSA
- Completed PSC-35 if applicable
- Documented the need for case management in the assessment if considering providing case management services.
- Completed a safety plan if you have assessed any risk factors within the past 90 days and include an objective related to containment.
- Documented any cultural, linguistic, physical limitations in the Assessment
- Completed Assessment with required co-signatures

Planned Services

An approved Client Plan must be in place prior to service delivery for the following Specialty Mental Health Services (SMHS):

- Individual, Group, and Family Psychotherapy; Individual and Group Rehabilitation; Collateral; and Medication Services
- Intensive Home Based Services (IHBS)
- Monitoring activities of Intensive Care Coordination (ICC)
- Monitoring activities of Targeted Case Management/Brokerage
- Therapeutic Foster Care (TFC)
- Therapeutic Behavioral Services (TBS)

Initial Client Plan

- The initial Client Plan is due within 60 calendar days of episode opening date (EOD) is day 1.
- The Client Plan is effective the date of the provider's signature. After this date, all planned services as outlined on the plan may be billed.
- Every subsequent Plan is due on a 12 month cycle, completed within the 30 day period prior to the first day of the month of EOD.

  Example: EOD 8/18/20

  The initial plan is due by 10/17/20

  The second treatment can be completed anytime between 7/1/21 and 8/1/21 but no later than 8/1/21.

Client Plans – Additional Timeline Requirements

- The Client Plan must be updated annually prior to the first day of the month of EOD.
- The Client Plan must also be updated whenever there is an event of clinical significance.
    - Events of clinical significance can include but are not limited to:
        - Client has made significant progress and reached their target goal
        - Client has increased suicidal/homicidal ideation
        - Client is hospitalized for psychiatric reasons (especially if this is a new bx)
        - Client is sanctioned for behaviors (school expulsion, legally detained).

Interim Assessments to Allow Earlier Development of Treatment Plans

- If staff/programs do not have enough time to complete a full mental health assessment (with all required elements) before completing a treatment plan, an Interim Assessment can be completed.
- An Interim Assessment must include the essential medical necessity components:
  - A current included (“covered”) diagnosis
  - Signs and symptoms of the diagnosis that meet DSM5 criteria
  - Functional impairments as a result of that diagnosis
  - Level of impairment
  - Client’s ability to benefit from treatment.
- An Interim Assessment does not meet Medi-Cal requirements for a full completed Assessment. A full Assessment with all required elements must be completed by the due date.

Interim Assessments and Client Plans

- Programs that determine it is clinically indicated to provide certain planned services before completion of a full Assessment (example: want to get client into a group therapy session within the first week), may complete both an Interim Assessment and Client Plan to allow for those planned services.
  - Any Client Plan must always have the required Medi-Cal documentation components.
  - Any Client Plan that is informed/created by an Interim Assessment must be reviewed once the full assessment is completed, and updated as clinically appropriate.

Client Plan - Goals

- The client goals are the long-term hopes of the client and/or caregiver/parent, stated in their own words.
- Goals should focus on their personal vision of recovery, wellness, and the life they envision for themselves.
- It is invaluable for client engagement to services that they are able to verbalize their own treatment goals.
- You may include optional long term mental health goals which support the client's life goals by linking them to the specific mental health objectives.
- Providers assist the client in developing the short term mental health objectives that link to the client's long term goals and are the target of interventions.

Examples of Goals

"I want to continue my education and finish my diploma."

"I want to find a job and be able to support myself."

"I would like my child to do better in school."

Impairments/ Area of Challenges

- Indicate area(s) of challenges: Community Life, Family Life, Safety, School/Education, Vocational, Independent Living (ADL's), Health, Housing, Legal, SUD, Food/Clothing/Shelter, etc.
- Indicate level of challenges.
    - Moderate or Severe (remember to rate accordingly if documenting to a significant impairment in an important area of life functioning for medical necessity).
- Describe specific functional impairments related to the signs and symptoms of the primary mental health diagnosis.
    - i.e. For Case Management (C/M), must indicate need for C/M service, client is unhoused. Also, must indicate (1) which severe symptoms/impairments resulting from the mental health diagnosis prevent client from accessing/maintaining needed services, or (2) for child/youth, that the lack of such services (caretaker not providing) exacerbates child's mental health symptoms/impairments.

Client Plan – Mental Health Objectives

- Apply SMART (Specific, Measurable, Attainable, Realistic and Time-Bound) to all Client Plan objectives
- Must be mental health focused (not housing, employment, SUD treatment, etc.)
- Address symptoms, behaviors, or impairments identified in the assessment
- Strength-based objectives replace problematic symptoms with positive coping skills/behaviors/etc.

CANS/ANSA and Treatment Planning

- Designed to guide treatment planning and develop Treatment Plan goals and objectives.
- Need items rated a “2” or “3” should be addressed in the Treatment Plan.
- Strength items rated “0” or “1” may be used for strength-based planning.
- Used to monitor treatment progress and redevelop the Plan as necessary.

Creating a Mental Health Objective

- Consider the client's diagnosis.

  Example: Bipolar II F31.81

- Target the client's stated long term goal (consider the client's CANS/ANSA).

  Example: Improve ability to pay attention at work and finish job-related tasks.

- Identify with the client which symptoms/behaviors/impairments associated with the client's primary diagnosis they would like to work on.

  Example: "Diminished ability to think or concentrate nearly every day." Note: It helps to use the criteria from the DSM 5.

- Ask the client to estimate the number of times that symptoms and/or behaviors happen on a daily, weekly, or monthly basis?

  Example: Client reports experiencing difficulty concentrating on tasks on a daily basis because they worry that they are going to start a depressive episode or not be able to manage mood swings.

Creating a Mental Health Objective

- Ask the client how many times they want the symptoms/behaviors/impairments to decrease.
- Encourage the client to set realistic numbers.

  Example: Client will reduce the number of times that they experience difficulty concentrating on tasks from 7 days a week to 4 days or less.
- Develop a way to measure the change.

  Example: . . .as evidenced by client report.
- Develop a time frame.

  Example: . . .within the next 12 months.

Examples of Good Mental Health Objectives

- Example of an objective to reduce an impairment/symptom:

In the next 12 months, client will reduce the number of times that they experience difficulty concentrating on tasks from 7 days a week to 4 days or less as evidenced by client's self report.

- Example of a strength-based objective to increase positive behavior:

In the next 12 months, client will increase the number of times that they use positive coping skills when they have difficulty concentrating from 1 out of 10 times to 8 out of 10 to times as evidenced by client's daily journal.

Types of service intervention

- Identify the proposed type(s) of interventions to be provided along with a proposed frequency and duration.
- If a planned service intervention is not in the client plan it may not be claimed and will be disallowed.

Example:

  - Individual Psychotherapy 1x per week, and as needed, for 12 months
  - Case Management 1x per month, and as needed, for 12 months
  - Group Therapy 1x per week, for 12 months
  - Collateral 1x per month, and as needed, for 12 months.

Adding "AND as needed" to the frequency of the service intervention allows flexibility in the scheduling—however "as needed" alone will not suffice for frequency of intervention and "or as needed" is not allowed. Both would result in disallowances.

- Unplanned service interventions do not need to be listed in the plan.
  - Note that monitoring activities of ICC and Case Management / Brokerage are considered planned services and must be listed in the plan.

Types of service intervention

Types of interventions to be listed in the Client Plan with common frequencies and timeframes:

- Collateral (Includes: Collateral and Collateral-Caregiver) – Weekly and as needed, for 12 months
- Case Management (Planned F/U Services) – Weekly and as needed, for 3 – 12 months
- Medication Services (non-urgent)– Monthly and as needed, for 12 months
- Individual Therapy – Weekly and as needed, for 12 months
- Individual Rehabilitation – Weekly and as needed, for 12 months
- Group Psychotherapy – Weekly for 12 months
- Group Rehabilitation – Weekly for 12 months
- Family Therapy – Weekly for 12 months
- Collateral Family Counseling – 2x month and as needed for 12 months

Service interventions Continued

- Multi-Family Group Therapy – Weekly for 12 months
- Collateral Family Group – Weekly for 12 months
- TBS – Weekly and as needed, for 3 – 12 months
- ICC – Weekly and as needed, for 3 – 12 months
- IHBS – Weekly and as needed, for 3 – 12 months
- Therapeutic Foster Care (TFC) – Daily, for 3 – 12 months
- Psychological Testing (Includes Psych Test, Developmental & Neuropsych) – Weekly and as needed, for 3 months

Detailed Interventions

For each intervention it is best practice to include a detailed description.

- Must focus upon and address the identified functional impairments as a result of the mental disorder.
- Must be consistent with the client plan mental health objectives and the qualifying diagnoses.
- For Collateral it should include listing significant others (by names and/or roles) for whom contact is planned and indicating “and others as needed.”

Detailed Interventions

General enough to be inclusive, but specific enough to be illustrative.

Examples:

- Individual Rehab

  "Assist the client in re-engaging in pleasant social activities through the use of an activities chart and role-play to manage symptoms of anhedonia due to Major Depression."

- Collateral

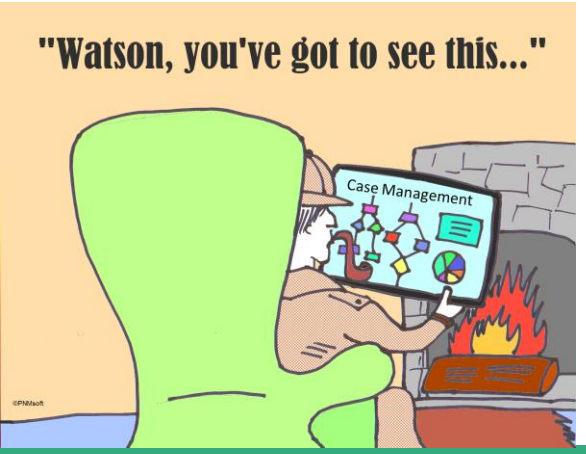
  "Contact with significant support persons of client including parents, teacher and school counselor (others as needed) to assist client in meeting their mental health goals and objectives."

- Medication Services

  "Medication Management strategies to engage client in collaboration to find, and optimize the dosage for effective anti-depressive medications."

Developing Client Plans to Include Case Management Services

- If Case Management Services (Brokerage/ICC) will be provided, the detailed interventions section of the plan should document the following:
  - Successful case management (linkage and monitoring) is expected to result in the client's mental health symptoms being reduced and client's mental health objectives being achieved.
  - Specific community resources that client will be linked to should be identified and documented.



Client Plan Required Signatures

- Client Plans are signed (or electronic equivalent) by:
  a) The person providing the service(s) or,
  b) A person representing a team or program providing the service(s) or,
  c) A person representing the MHP providing service(s).
- Client plan signatures must include the date of service, the signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title, relevant identification number (e.g., NPI number), if applicable, and the date the documentation was entered in the medical record.
- Client Plans must be finalized (unable to be further edited) and signed by all required clinical staff (including supervisor) before considered effective.

Client Plan Required Signatures

- All Client Plans must also be signed by the client and/or guardian.

  Clinical judgment should be used to determine if it is appropriate to review treatment plans with young children. If appropriate, obtain a client's signature. If not appropriate, obtain a client's guardian's signature.

- Client plans do not require a date to indicate when it was signed.

  If a client does not date their signature, a provider may add the date and include their initials.

Client Plan Required Signatures

- If the client does not sign or refuses to sign the Client Plan, regular efforts must be attempted to obtain the client's approval.
  - Note the issue on the client signature line in the Client Plan with a reference to a progress note. Elaborate in the Progress Note the rationale or reason why a signature was not obtained, and when the next attempt will occur.
- If the client's mental health symptoms (such as paranoia caused by schizophrenia) prevent client from reviewing and signing the treatment plan and it is determined that ongoing attempts are not clinically appropriate, this must be documented in a progress note. The unsigned treatment plan should reference this note.
- If a client does not sign a Client Plan due to unavailability (such as client no-showing to an appointment) future attempts must be made to obtain the client's signature. Unavailability (without other mitigating mental health factors) is not a reason to stop attempts to obtain a client signature.

Exceptions to Signature Requirements

- A client's signature on the Treatment Plan is not required when:
    - The client is not expected to be in treatment beyond 60 days.
    - Is only receiving one Specialty Mental Health Service (intervention)
        - Currently, the only ACBH programs claiming one intervention are Medication Services and TBS.
        - Remember that Collateral is considered a intervention.

All other requirements remain. For example, provider must document that client participated in the development, agreed to it, and was offered a copy.

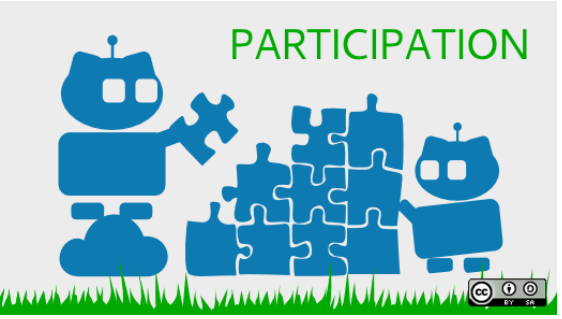
Note that even if one of these exceptions is met, it is highly recommended that the client sign their plan.

Signature Requirements during COVID-19

Will late signatures (Informing Materials, Consents, Client Plan and Medication Consents) be accepted as compliant for claiming purposes if verbal consent is provided?

- Yes, for certain documents. Document as follows: In the PN, explain what information was shared with the client, that the client verbally consented to the information provided, and that they will sign the forms at the next in-person meeting as they cannot currently meet in-person due to the COVID-19 emergency.
- Releases of Information require an actual client signature.
- DHCS has indicated that if a COVID-19 situation has caused the client to be unavailable to sign a Client Plan, this can be documented and there is no need to seek a signature after the shelter in place is lifted. For this reason, a Client Plan lacking a wet signature can be approved in CQRT and there is no need to wait on review or approval of a chart.

Participation in the Creation of the Client Plan



- The clinical record must document the client's participation in the development of the Plan, agreement with the client's Plan, and that the client was offered a copy of their Plan.
    - The client's signature on the Plan alone does not meet these requirements
- This information may be documented in progress notes and/or in the body of the Client Plan itself.

Discharge Plan

- Discharge planning should be started at the time of admission and discussed regularly over the course of treatment.
- The Client Plan must contain a tentative discharge plan, which includes an anticipated timeframe, readiness indicators, and/or possible referrals at discharge.

Discharge Plan

Questions to consider with the client:

- What is getting in the way of the client meeting their goals/objectives?
- What will the client be doing differently as a result of treatment?
- How would you or the client know that they were ready to move on from treatment?
- Who is in the client's support system, and how can they support client in discharge planning?
- What services are available to the client after they leave this program?
- What referrals need to be made (if any) to make services available to the client upon termination?
- What life/coping skills need to be learned/taught during treatment in order for the client to maintain their treatment objectives?
- What triggers might the client face after leaving and how will they deal with these without the support of the current provider?

Updating Client Plans

- Providers must be attentive to the need to update changes in the treatment plan through-out the year. Department of Health Care Services and ACBH Quality Assurance will disallow notes if the Client Plan has not been updated to reflect new client goals, mental health objectives, and events in the client's life.
    - Examples of events requiring a change to the Treatment Plan include, but are not limited to: hospitalization, new thoughts or behaviors of self-harm or dangerousness to others, additions of new service interventions (i.e. medication services, case management, group rehab, individual therapy, etc.)

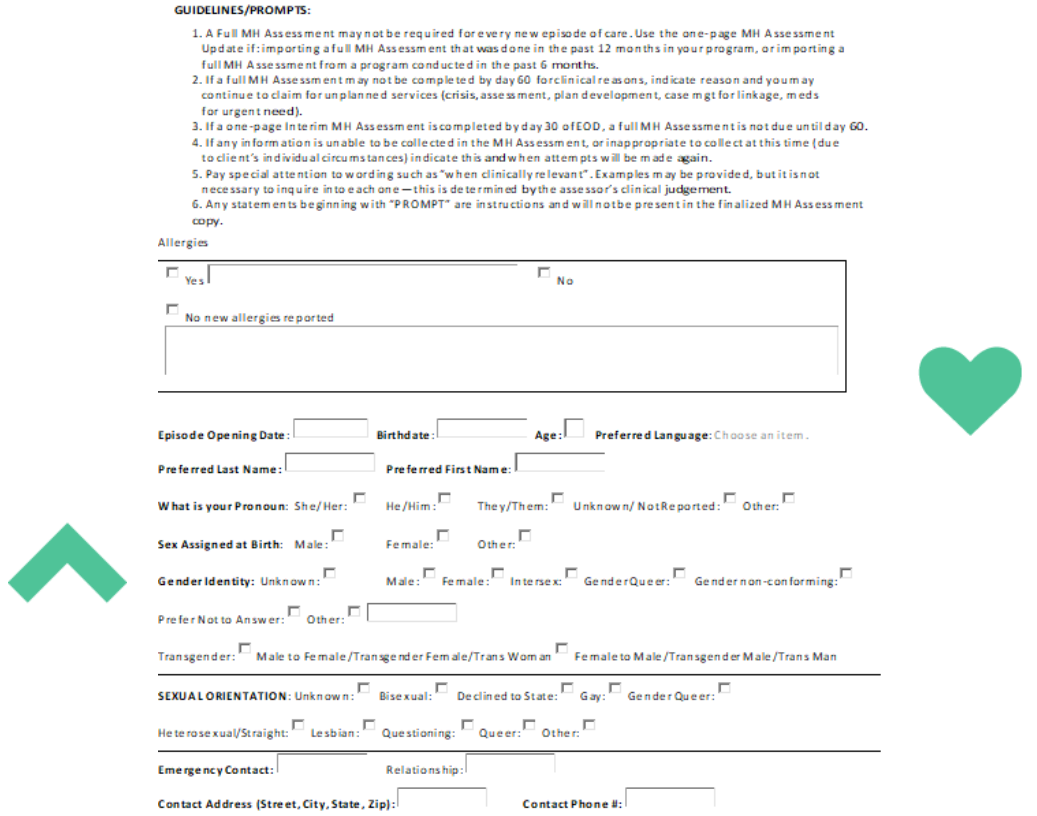
Medi-Cal Compliant Client Plan Form Templates

ACBH/Forms/

Clinical/Adult or Child/

Plan

http://www.acbhcs.org/providers/Forms/AdultForm.htm



GUIDELINES/PROMPTS:

1. A Full MH Assessment may not be required for every new episode of care. Use the one-page MH Assessment Update if: importing a full MH Assessment that was done in the past 12 months in your program, or importing a full MH Assessment from a program conducted in the past 6 months.
2. If a full MH Assessment may not be completed by day 60 for clinical reasons, indicate reason and you may continue to claim for unplanned services (crisis, assessment, plan development, case mgt for linkage, meds for urgent need).
3. If a one-page Interim MH Assessment is completed by day 30 of EOD, a full MH Assessment is not due until day 60.
4. If any information is unable to be collected in the MH Assessment, or inappropriate to collect at this time (due to client's individual circumstances) indicate this and when attempts will be made again.
5. Pay special attention to wording such as "when clinically relevant". Examples may be provided, but it is not necessary to inquire into each one — this is determined by the assessor's clinical judgement.
6. Any statements beginning with "PROMPT" are instructions and will not be present in the finalized MH Assessment copy.

Allergies

☐ Yes ☐ No

☐ No new allergies reported

Episode Opening Date: **Birthdate:** **Age:** **Preferred Language:** Choose an item.

Preferred Last Name: **Preferred First Name:**

What is your Pronoun: She/Her: ☐ He/Him: ☐ They/Them: ☐ Unknown/ Not Reported: ☐ Other: ☐

Sex Assigned at Birth: Male: ☐ Female: ☐ Other: ☐

Gender Identity: Unknown: ☐ Male: ☐ Female: ☐ Intersex: ☐ Gender Queer: ☐ Gender non-conforming: ☐

Prefer Not to Answer: ☐ Other: ☐

Transgender: ☐ Male to Female/Transgender Female/Trans Woman ☐ Female to Male/Transgender Male/Trans Man

SEXUAL ORIENTATION: Unknown: ☐ Bisexual: ☐ Declined to State: ☐ Gay: ☐ Gender Queer: ☐

Heterosexual/Straight: ☐ Lesbian: ☐ Questioning: ☐ Queer: ☐ Other: ☐

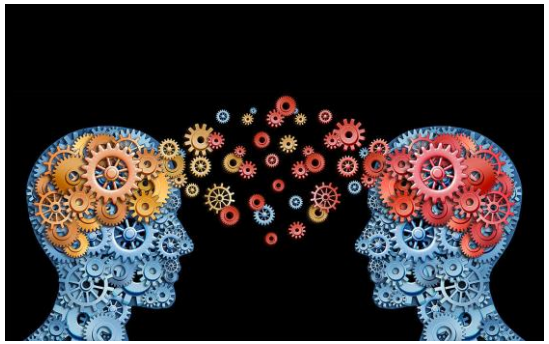
Emergency Contact: Relationship:

Contact Address (Street, City, State, Zip): **Contact Phone #:**

Example of a Non-Billable Client Plan

- Mental Health Objective: Client will obtain stable housing within 6 months; temporarily living with a friend. [Not a MH Objective]
- Service intervention : Case management 1x/week and as needed for 1 year
- Detailed Interventions: Case management - Case manager will work with client to apply for housing and assist client in filling out necessary forms. [Case mgt is not acting as a housing support specialist—but is linking to and monitoring client's participation in such services.]

Sharing Assessments and Treatment Plans



- Agencies with multiple Reporting Units (RUs) that share a medical record are allowed to share one mental health Assessment and Treatment Plan for concurrent services.
  - Example: If a client is receiving therapy services in one RU, and begins to receive medication services in a different RU, both RUs/providers may share the Assessment and Treatment Plan.
  - Open each RU with the date the client was first opened at the agency.
- Any documentation that is in need of updating must be addressed within the agency.
  - For example, informed consent must be completed when new interventions are added to the plan.
  - Multiple RUs within an agency may decide to share a plan or create a new Treatment Plan.
  - Adding an additional intervention will always require a new plan.

Sharing Assessments and Treatment Plans

- If multiple RUs (in one agency) do not share a chart, all shared documentation must be copied into each chart. This includes documents from the initial episode opening date such as:
  - Screening Form (with associated progress notes)
  - Informing Materials (with associated progress notes)
  - Mental Health Assessments (with associated progress notes)
  - CANS/ANSA (with associated progress notes)
  - Client Treatment Plan (with associated progress notes)
  - Release of Information (with associated progress notes)
- For ACBH county clinics, “one agency” is considered one program which has a unique folder in the Laserfiche database.

Sharing Assessments and Treatment Plans

For Initial Assessments Only

If a full Assessment has been completed for a client it is possible for providers to use this Assessment and update it under the following circumstances:

- Full Assessment completed within the same agency in the last 12 months.
- Full Assessment completed by another agency in the last 6 months.

Sharing Assessments and Treatment Plans

- To use a previously completed Assessment, the following should occur:
  - A copy of the Assessment should be placed into the chart.

  The Assessment content should be reviewed with the client to assure accuracy.
  - An Assessment Addendum must be completed that includes:
    - Interim History
    - Any changes in all of the areas of the MH Assessment previously collected
    - A current included diagnosis
    - Signs and symptoms of the diagnosis that meet DSM 5 criteria
    - Functional impairments as a result of the diagnosis
    - Level of impairment
    - Client's ability to benefit from treatment

Client Plan Review

- May Collateral services be claimed before completion of the Client Plan?
  - No
- Name three reasons that all planned services may be disallowed in a chart:
  - Assessment not done initially and annually
  - Client Plan not done initially and annually and when clinically indicated—or not signed by provider and client/representative
  - Service intervention for a planned service is not listed in Client Plan

Client Plan Review

- When must the CANS/ANSA be completed?
  - As part of the assessment process and before completion of the Client Plan
  - Every 6 months (based on episode opening)
  - At discharge.
- What is the Treatment Plan Cycle for a case that is opened on August 23rd?
  - August 1st – July 31st each year.
- When a Case Management need arises before completion of the MH Assessment and/or Client Plan, may it be claimed as such?
  - Only if it for the purposes of referral and linkage
- When must all services of a certain type (i.e. Ind Rehab) be disallowed across the whole chart (episode of care)?
  - When the service intervention is not listed in the Client Plan.

Keep In Touch with QA

Follow up Documentation Questions QATA@acgov.org

- Privacy Incidents should be reported via BreachNotification@acgov.org
- Unusual Occurrences should be sent to QAOffice@acgov.org
- Professional Licensing Waivers should be sent to QAOffice@acgov.org or eFAX (510) 639-1346
- Whistleblower reports should be received via ProgIntegrity@acgov.org
- Grievance and Appeal Requests should be sent by mail or to QAOffice@acgov.org
- Training inquiries should be received via QAOffice@acgov.org
- NOABDs should be received via eFAX (510) 639-1346

Alameda County Behavioral Health
Care Services

thank you.