County of Sacramento **Department of Health Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**QM**
	Policy Number	**QM-10-27**
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Title: **Client Plan**	Functional Area: **Chart Review – Non-Hospital Services**	
Approved By: (Signature on File) **Signed version available upon request** **Alexandra Rechs, LMFT** Program Manager, Quality Management		

BACKGROUND/CONTEXT:

The Client Plan is the fundamental tool used by Sacramento County Division of Behavioral Health Services (BHS) and Mental Health Plan (MHP) providers to guide treatment and service delivery. The Client Plan is dynamic in nature and developed in mutual collaboration between client, caregiver/support persons and provider and establishes the foundation for treatment.

PURPOSE:

The purpose of this policy is to outline guidelines, requirements, and timelines for developing and finalizing the Client Plan.

The Client Plan documents the mutual collaboration efforts between the client, family/ caregiver/significant supports person(s) and provider to address time-defined mental health treatment goals. The Client Plan must be individualized, culturally responsive and holistic, and focus on the client's desired outcomes. A copy of the Client Plan must be offered to the client and family/caregiver/significant support person(s) and is considered part of a comprehensive client record.

The following policy provides clinical guidelines for completion of the Client Plan.

DEFINITIONS:

As used in this policy, the following capitalized terms shall have the following meanings:

Admit Date: The date that the beneficiary is assigned to the specialty mental health provider.

Assessment Start Date: This is the first billed assessment that the MHP provided to the client. This assessment may be started by the Access Team for new referrals; APSS Team for unlinked referrals from inpatient psychiatric settings or Providers who do their own admissions. The first Medi-Cal billable service initiates the timeline for the Clinical Bundle.

Clinical Bundle: The required documentation to be completed by the assigned provider including Assessment Documents and Client Plan. Refer to QM Documentation Training: CWS Documentation Bundles and your contract for the specific required documentation.

Long Term Beneficiary: A client is considered to be a "Long Term Beneficiary" when the client has been opened to an outpatient specialty mental health provider and receives services for over 60 days from the Assessment Start Date or first Medi-Cal billable service.

Paperwork Cycle: Begins at the Assessment Start Date/first Medi-Cal billable service. The Clinical Bundle must be finalized 60 days from the Assessment Start Date or first Medi-Cal billable service and annually at minimum.

Significant Support Person: Persons, in the opinion of the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a beneficiary who is a minor, the legal representative of a beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary's spouse, and relatives of the beneficiary.

DETAILS:

It is the policy of the DBHS that a Client Plan be completed for all clients.

1. The initial Client Plan is required to be completed within sixty 60 days from the start of service (Assessment Start Date) or first Medi-Cal billable service.

2. The initial Client Plan is not required if the case is closed prior to 60 days from the (Assessment Start Date) or first Medi-Cal billable service.

3. The Client Plan is required to be completed annually at minimum. There may be times when the Client Plan is updated more frequently such as when there are significant changes in the client's mental health condition, and more frequently if stipulated for a specific program.

4. The following services require authorization and must submit request for re-authorization to the Mental Health Access Team in addition to completing and finalizing the Client Plan and Clinical Bundle, if applicable, prior to the end of authorization: Assessment only, Psychological Testing, Day Rehabilitation Services, Day Treatment Intensive Services, Therapeutic Behavioral Services, Enrolled Network Provider, Out of County Contracts, ECT, TFC and IHBS. For all other services, payment of services is dependent upon the client continuing to meet Medical Necessity, meet Target Population and having an active Client Plan based off of an Assessment.

5. Providers risk fiscal disallowance or recoupment if the Client Plan is not completed and finalized within the defined timeframes and conditions as specified in Details #1 and #3 above.

6. All non-emergency planned services provided after the first 60 days from the Assessment Start Date or first Medi-Cal billable service without a Client Plan will be disallowed. Services claimed during a "gap" in Client Plans or that are not included in the current Client Plan will also be disallowed.

7. All services claimed during a time period in which the Client Plan did not meet required criteria will be disallowed and subject to recoupment if not corrected in the electronic health record billing and claiming system.

8. The Client Plan must electronically signed and finalized by staff identified in the Avatar CWS Documentation Requirements Matrix to be considered complete. The qualified staff who co-created the Client Plan with the client and significant support person(s), if applicable, is required to sign the Client Plan. If the qualified staff who completed the Client Plan is not licensed or licensed waived then the Client Plan must be co-signed by a licensed or licensed waived staff.

9. The Client Plan must include evidence of client/guardian/caregiver/significant support person(s)/ conservator participation and agreement, addressed by obtaining signatures. There must also be documentation in the progress notes of the medical record describing the client's participation and agreement with the Client Plan.

10. The client's signature is required if in the opinion of the staff the client is mature enough to participate intelligently in the treatment. If, for some reason, the signature cannot be obtained electronically, the hard copy of the Client Plan may be signed and scanned into the record, with appropriate documentation of the reason signature(s) were not able to be obtained on both the Client Plan and in the Progress Notes. Once signatures have been obtained by these parties the Client Plan is considered complete and cannot be altered in any way. A Client Plan is able to be updated as needed. If the client refuses to sign the Client Plan then document on the Client Plan a written explanation of the refusal or unavailability of the signature as well as document in subsequent service notes any efforts to obtain signatures in the progress notes, when applicable.

11. The Client Plan is developed from the Assessment, must be consistent with the diagnosis, impacts on life functioning and quality of life, and must substantiate ongoing Medical Necessity. The Client Plan must also be individualized and relate back to the client's mental health condition. The mental health condition is based on the inclusion of specific signs, symptoms, and conditions. A mental health condition impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis. Each person will have different experiences, even people with the same diagnosis.

12. Consider relevant assessment screenings, such as the Child Adolescent Needs and Strengths (CANS), Pediatric Symptom Checklist (PSC-35), and Adult Needs and Strengths (ANSA) when formulating the Client Plan. Considerations may include considering needs, problem areas and strengths while co-creating objectives or factoring in ongoing planned interventions to address needs.

13. The Client Plan offers space for clients to provide input "in their own words." Seeking and obtaining client input is crucial to successful treatment outcomes.

14. The Provider must incorporate client/family/caregiver/significant support person(s) strengths and challenges and make every effort to follow strength-based and recovery/resiliency oriented treatment planning.

15. A Client Plan Report format must be used when a printed "hard copy" form of the document is needed, such as when providing a copy of the Client Plan to the client or in response to a request for records.

16. A copy of the Client Plan Report must be provided or offered to the client and family/caregiver/significant support person(s) (or legal representative) upon completion, as consented by the client. It must be documented that the Client Plan Report was offered and whether the client received a copy of that document. Subsequent copies of the Client Plan Report must be made available upon request by the client/family/caregiver/significant support person(s), as consented by the client.

PROCEDURE:

The Client Plan is an interconnected document that may be understood using a waterfall model beginning with the first element, Reasons for Services, followed by Goals, Objectives, Interventions, and Participation. These five elements are linked and intended to flow in a logical and sequential order.

The Client Plan elements and requirements are explained below:

1. The first Client Plan element, "Reasons for Services", are drawn from areas identified in the Core Assessment that support Medical Necessity. The reasons focus on the client's mental health, including symptoms, behaviors and level of impairment, and psycho social conditions such as living situation, daily activities and social support.

a. This may include observed, client reported, and family/significant support person(s), if applicable, reported reason for services that impact the client's level of functioning. Connecting Reasons for Services helps ensure the link between the Core Assessment and the Client Plan.

b. Invite the client to share the reason for services in their own words, and document within the "Client's Reasons for Services in Their Own Words" section.

2. The second Client Plan element, "Goals", may be broad or specific, and should be linked to and address the Reasons for Services. Treatment should have a positive impact on the Goals and ultimately improve the client's level of functioning.

   a. Document the client's strengths and barriers identified by the client and provider during the assessment process. Strengths are used in treatment planning to help promote client's success in reaching their goals. Barriers may be viewed as challenges having potential to reduce or impede progress toward achieving goals. Knowledge of strengths and barriers help in developing goals that are realistic and achievable. Invite the client to share goals in their own words to reinforce an individualized approach to services.

3. The third Client Plan element is "Objectives", which are the specific observable, and/or specific quantifiable steps taken to help the client meet their treatment goals. Objectives focus on the client's mental health condition, including symptoms, behaviors and level of functioning. Culture must be taken into consideration when defining objectives. Using action words to describe may be useful because objectives often reflect changes in behavior, functional level, or skill. Quantifiable objective(s) often require the client/family to practice and master new skills and behaviors to support more effective responses to challenges. Examples of ways to measure objectives include observation, self-report, standardized tests, screening tools and behavior charts. An objective may begin with "the client will…" describing the specific change in behavior skills needed to reach the goal.

   a. An objective must indicate a frequency and be time specific. A quantifiable objective is one where change can be observed by client, family and provider.

   b. Invite the client/family to share objectives in their own words.

4. The fourth element is "Interventions." Interventions are strategies and actions taken by the client, provider, and caregiver/significant support person(s) to meet the Client Plan objectives. Interventions must be consistent with the mental health goal(s) and objective(s). The proposed interventions are expected to have a positive impact on the "Reasons for Services." Interventions/modalities recorded on Client Plans are clear, specific and address the client's identified functional impairments as a result of the mental health condition.
   a. The intervention(s) must address the mental health condition identified, or for client's under the age of 21 years, a condition as a result of the mental health disorder or emotional disturbance that Specialty Mental Health Service can correct or ameliorate. Interventions must also do at least one of the following:
      i. Significantly diminish the impairment.
      ii. Prevent significant deterioration in an important area of life functioning.
      iii. Allow the child to progress developmentally as individually appropriate.
      iv. For client's under the age of 21 years, correct or ameliorate the condition. Also, the condition would not be responsive to physical health care based treatment.

   b. Must identify the proposed type(s) of interventions or modality, including a detailed description of the interventions to be provided.

   c. Must include the proposed frequency of interventions. This must be specifically how often the services will occur for each intervention and must be either a number (e.g., "1x per week") or a

range (e.g., “1-4x” per month). Terms such as, “as needed” or “as clinically indicated” do not meet the requirement for proposed intervention frequency.

d. Must include the proposed duration of interventions. This is the total expected time span of service(s).

e. Must focus and address the identified functional impairments as a result of the mental health disorder or emotional disturbance.

f. Must be sufficient in amount, duration and scope.

g. Must be consistent with the qualifying diagnosis.

h. Must include all planned interventions, regardless of funding, tied to the service modality.

5. The fifth Client Plan element, “Participation”, addresses support and coordination of the client’s care with other people in the client’s life, both personal and professional. Examples of a personal support include a family member and examples of a professional support include a Primary Care Physician.

6. Signatures are required on the Client Plan.

   a. The qualified staff’s signature is required within 60 days of the Assessment Start Date or first Medi-Cal billable service and on all Client Plan Updates. Annual and Client Plans Updates require the qualified staff’s signature upon completion. If required, as identified in the Avatar CWS Documentation Requirements Matrix, supervisor approval must also be obtained on all applicable Client Plans.

   b. The client’s and/or family/caregiver/significant support person(s) (or legal representative) must also sign the Client Plan within the 60 day from the Assessment Start Date or first Medi-Cal billable service. Annual and updated Client Plans require client’s and/or guardian/caregiver (or legal representative) signature.

If the client and/or family/caregiver/significant support person(s) (or legal representative) is unavailable or refuses to sign the Client Plan, the identifying reasons for no signatures or unavailability must be documented on the Client Plan and in the progress notes. Progress notes must document ongoing explanations and follow-up efforts to obtain the signature, when applicable.

For technical assistance with entering the Client Plan in Avatar or other electronic health records please contact Avatar: http://www.dhhs.saccounty.net/BHS/Avatar/Pages/Avatar.aspx

REFERENCE(S)/ATTACHMENTS:

- The Mental Health Plan Contract
- 9 CCR § 1810.204 Assessment
- 9 CCR § 1810.205.2 Client Plan
- 9 CCR § 1810.440 MHP Quality Management Programs
- 9 CCR § 1810.246.1 Significant Support Person
- MHSUDS IN#17-040

RELATED POLICIES:

- QM 10-26 Core Assessment
- QM 01-07 Determination for Medical Necessity and Target Population
- Access 02-04 Authorization Requests

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CONTACT INFORMATION:

- Quality Management Information
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