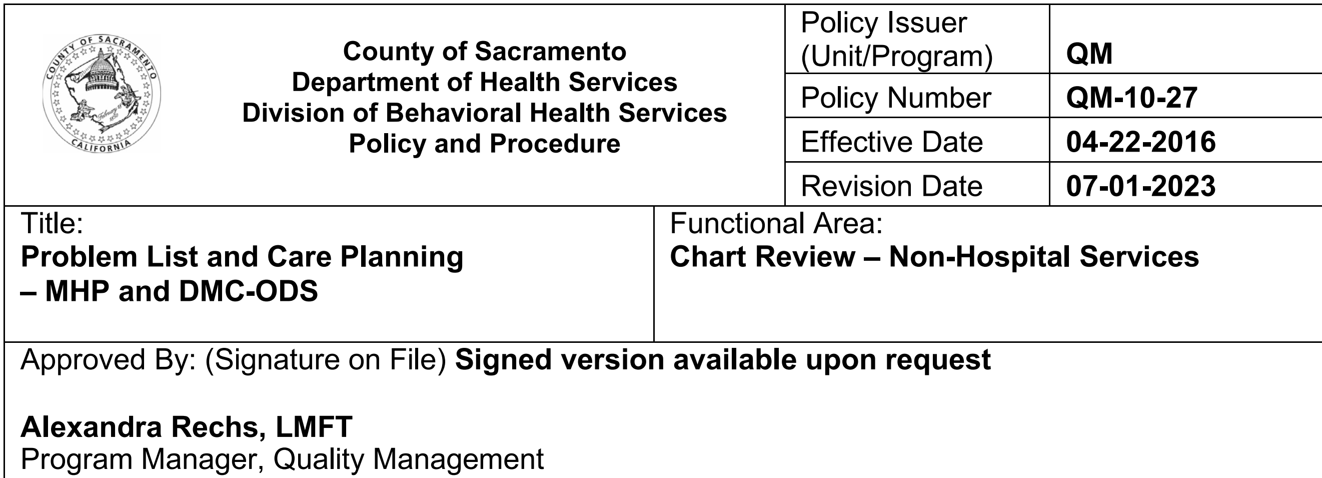

County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	**QM**
	Policy Number	**QM-10-27**
	Effective Date	**04-22-2016**
	Revision Date	**07-01-2023**
Title: **Problem List and Care Planning – MHP and DMC-ODS**	Functional 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:

With the implementation of CalAIM there have been significant changes made to client plans. In the past, client plans were static and complicated documents with strict start and end dates. If services were provided that were not documented on the client plan, they could not be claimed. Persons receiving care had to sign the client plans or they were not considered valid.

Over time it has become clear that effective treatment planning involves a more dynamic process since the member's needs are dynamic and can change rapidly. As part of CalAIM, the use of a problem list has largely replaced the use of client plans, except where federal requirements mandate a client plan be maintained. The problem list will be completed by different members of the treatment team to capture the issues needing attention. When used as intended, treatment team members can use the problem list to quickly gain necessary information about a person's concerns, how long the issue has been present, the name of the practitioner who recorded the concern, and track the issue over time, including its resolution. DHCS has removed the client plan requirements from specialty mental health services (SMHS) and treatment plan requirements from DMC and DMC-ODS, with the exception of some services that maintain that requirement per applicable federal regulations or guidance. Services that continue to require a client plan are moving from standalone documents to be embedded in progress notes. Going forward these will be referred to as a Care Plan.

PURPOSE:

The purpose of this policy is to establish guidelines for utilizing the problem list to identify the focus of treatment and to identify when a care plan continues to be required for specific types of services.

A key outcome of the assessment process is the generation of shared agreement on the strengths and needs of the member, as well as how to best address those needs. Goal setting is accomplished through mutual collaboration efforts between the member, family/ caregiver/significant supports person(s) and provider to address mental health and/or substance use needs as identified in the assessment. The problem list or care plan must be individualized, culturally responsive and holistic, and focused on the member's desired outcomes. The following policy provides clinical guidelines for completion of the problem list and care plan.

DEFINITIONS:

Enrollment Date: The date that the member is opened to the Mental Health Plan (MHP) or Drug

Medi- Cal Organized Delivery System (DMC-ODS) provider.

Clinical Bundle: The required documentation to be completed by the assigned provider including assessment Documents, problem list and care plan. Refer to QM Documentation Training: Documentation Bundles and your contract for the specific required documentation.

Significant Support Persons: Persons, in the opinion of the member 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 member who is a minor, the legal representative of a member who is not a minor, a person living in the same household as the member, the member's spouse, and relatives of the member.

DETAILS:

It is the policy of the Department of Behavioral Health Services (DBHS) that a problem list be compiled for each member and when required for specific service types, a care plan must be completed.

Problem List: The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The problem list is not program specific and can be viewed across Mental Health Plan (MHP) providers; while for DMC-ODS Providers the problem list can only be viewed within each DMC-ODS Provider site. If a problem exists on the list and has not been end dated by a previous provider, it is not necessary to add it again to the problem list. Documentation within the progress notes should include the areas of need indicated in the assessment. Upon discharge from a Program, there may continue to be relevant problems that remain on the problem list. It is not required to end date a remaining relevant problem as that may be pertinent to linking and referring a member to ongoing necessary services.

1. A problem should be identified during a service encounter, may be addressed by the service provider during the service encounter, and subsequently added to the problem list. Member’s voice and choice is encouraged, including the member goals in their own words, and acknowledge their resiliencies and self-worth.

2. The Problem List shall include, but is not limited to, the following:
    a. Diagnoses, if any, identified by a provider acting within their scope of practice. (Include diagnostic specifiers from the DSM if applicable).
    b. Problems, if any, identified by a provider acting within their scope of practice.
    c. Problems or illnesses, if any, identified by the member and/or significant support person.
    d. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

3. Providers shall add to or remove problems from the problem list when there is arelevant change to a member’s condition. The problem list does not have a requirement to be updated within a specific time frame or frequency.

4. In addition to the problem list, for billing purposes, the diagnosis form in the Electronic Health Record (EHR) must be completed.

5. To support consistency in documentation, refer to attachment A for the most common diagnosis crosswalk for ICD- 10, SNOMED and DSM Codes. Please refer to QM 01-07 Determination for Medical Necessity and Access to Specialty Mental Health Services for more information regarding determination of medical necessity.

Care Plan: The use of a problem list has largely replaced the use of treatment plans, except where federal requirements mandate a treatment plan be maintained. The following service types will continue to require either a care plan:

1. Care Plan within the Progress Notes – There are ten service types that require a brief care plan to be included within the body of a progress note within the care plan section. These notes will include the elements of the Care Plan listed below. The following will also require the use of the problem list unless otherwise specified.

    a. Targeted Case Management/Case Management
    b. Peer Support Services
    c. Therapeutic Behavioral Services (TBS)
    d. Intensive Home-Based Services (IHBS)
    e. Intensive Care Coordination (ICC)
    f. Therapeutic Foster Care (TFC)
    g. Short Term Residential Therapeutic Programs (STRTP)
    h. Narcotic Treatment Programs (NTP) (*Do not require use of the Problem List)
    i. Social Rehabilitation Programs (including Crisis Residential)
    j. MHSA FSP (ISSP)

2. Targeted Case Management/ Case Management documentation must address 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:
    a. Services are being furnished in accordance with the individual's care plan.
    b. Services in the care plan are adequate.
    c. 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 when there are changes in the needs or status of the eligible individual.
    d. Monitoring of the care plan is conducted on an annual basis.

3. For members with Medicare: According to Medicare Benefit Policy Manual, Chapter 6, Section 70.1, Treatment Plans must meet the following requirements: ".must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services are furnished.)" This care plan will be written within the progress note.

4. The time period for providers to complete an initial and subsequent care plans is up to clinical discretion; however, providers shall complete care plans within a reasonable time and in accordance with generally accepted standards of practice. Sacramento County considers it best practice to complete the care plan within 90 days, unless there is documentation of any issues (i.e., acuity, homelessness, difficulty with engagement) that prove to be a barrier to completion. Care Plans not completed during these timelines will

not result in recoupments. It is the responsibility of the provider to ensure care plans are completed in accordance with all applicable oversight and authority pertaining to the services that they provide.

5. Discharge/Transition Plan – A discharge/transition plan should be developed early on to prepare for when a member has achieved the goals of the care plan.
    a. Considerations may include:
        i. Step down criteria considerations
        ii. Decrease in symptoms, behaviors and improvement in functioning
        iii. Decrease in risk factors and increase in safety
        iv. Decrease in California Child Adolescent Needs and Strengths (CANS), / California Adult Needs and Strengths (ANSA) needs scores and/or American Society of Addiction Medicine (ASAM)/ Substance Use Disorder (SUD) Assessment Scores
        v. Stability in their living arrangement, economic needs, personal health care and social, cultural and spiritual needs
        vi. Considerations and referrals for on-going mental health and/or substance use treatment
    b. The discharge/transition plan should be reviewed throughout the course of treatment and revised as applicable.
    c. When the member has made progress toward their goals the discharge/transition plan the provider should support the member with following through on that plan. This should include linkage to step down treatment options, community, natural supports, and information about how to access SMH or DMC-ODS services if there is an increase in symptoms or need in the future. Problems identified in the problem list should be reviewed and end dates added for problems that have been resolved. Current or unresolved problems should remain on the problem list in the event the member is open to other DBHS providers or discharge reports are provided to the Managed Care Plan (MCP) during step down transitions utilizing the Transition of Care tool.

PROCEDURE:

Accuracy of the diagnoses and problem list are necessary for appropriate treatment services to a member, and to support claiming for services. Inconsistencies in either can lead to poor coordination of care across teams and treatment as well as inadequate documentation of the medical necessity of SMH and/or DMC-ODS services.

Consider relevant assessment screenings, such as the California CANS, Pediatric Symptom Checklist (PSC- 35), Standard Comprehensive ANSA 3.0, and ASAM/ SUD Assessment when formulating the care plan and adding to the problem list. For the care plan considerations may include considering needs, problem areas and strengths while co-creating goals or factoring in ongoing planned interventions to address needs.

Problem List: The problem list form in the EHR will be used when an issue has been identified by member and service provider and will identify when an issue has been resolved. MHP and DMC-ODS will document the problems within the respective problem list and complete all areas.

Elements of the Care Plan within Progress Notes: The care plan section of the progress note would contain the following minimum elements documented in narrative format:

1. Specify the goals, treatment, service activities/interventions, and assistance to address the agreed upon objectives of the plan and the medical, social, educational and other services needed by the member;
2. Include activities/interventions such as ensuring the active participation of the member, and working with the member (or the member's authorized health care decision maker) and others to develop those goals;
3. Identify a course of action to respond to the assessed needs of the member; and
4. Include development of a transition plan when a member has achieved the goals of treatment. This should include step down treatment options, community, natural supports, and information about how to access MHP or DMC-ODS services if there is an increase in symptoms or need in the future.

Documenting the Care Plan:

1. In the EHR SmartCare, the care plan section of the progress note is dependent upon the procedure code that you select. If you select a service code that requires a care plan, then the care plan section would automatically show up as a section under the note tab.
2. Signature requirements
   a. Member signature is no longer required on plans. Provider signature and credentials will be required within the progress note containing the care plan.
   The qualified staff's signature is required on the service note within a clinically appropriate timeframe and following service note timelines.

Communicating the Content of the Care Plan:

1. To support delivery of coordinated care, the provider shall be able to produce and communicate the content of the care plan to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws.

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
- BHIN# 22-019

RELATED POLICIES:

- QM 10-26 CalAIM Assessment
- QM 01-07 Determination for Medical Necessity & Access to Specialty Mental Health Services
- Access 02-04 Authorization Requests
- SUPT 11-02 EHR and Documentation

- SUPT 03-01 Drug Medi-Cal Organized Delivery System Overview

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff		
X	Mental Health Treatment Center		
X	Adult Contract Providers		
X	Children's Contract Providers		
X	Substance Use Prevention and Treatment		
	Specific grant/specialty resource		

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