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	**07-01-2022**

Title: **Problem List, Treatment, 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 significant changes will be made to documentation requirements including client plan. 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 client needs are dynamic and can change rapidly. As part of CalAIM, Client Plans for many types of services are moving from standalone documents to be embedded in progress notes with a few exceptions. Going forward these will be refered to either a Care Plan or Treatment Plan depending on the program.

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 or Treatment 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 beneficiary, as well as how to best address those needs. Goal setting is accomplished through mutual collaboration efforts between the beneficiary, 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, Care Plan, or Treatment Plan must be individualized, culturally responsive and holistic, and focused on the beneficiary's desired outcomes. The following policy provides clinical guidelines for completion of the Problem List, Care Plan, and Treatment Plan.

DEFINITIONS:

Admit Date: The date that the beneficiary is assigned to the Mental Health Plan (MHP) or Drug Medi-Cal Organized Delivery System (DMC-ODS) provider.

Assessment Start Date: This is the first billed assessment that the MHP provided to the beneficiary. The assessment would be completed by the assigned Provider. The first Medi-Cal billable service initiates the timeline for the Clinical Bundle. This applies to both MH and DMC-ODS in their respective Assesssment Forms.

Clinical Bundle: The required documentation to be completed by the assigned provider including Assessment Documents and Treatment 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 behavioral health provider and receives services for over 60 days from the Assessment Start Date or first Medi-Cal billable service.

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 Problem List be compiled for each beneficiary and when required for specific service types, a Care Plan or Treatment 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 non-episodic and can be viewed across Mental Health Plan (MHP) providers. 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.

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. Client’s voice and choice is encouraged, including the beneficiary 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 beneficiary 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 a relevant change to a beneficiary’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 EHR must be completed.

5. To support consistency in documentation attachments A and B for crosswalk for ICD-10/SNOMED and DSM Codes should be referenced.

Care Plan and Treatment 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 or a Treatment plan:

1. Care Plan within the Progress Notes – There are two service types that require a treatment plan to be included within the body of a Progress Note. These notes will include the Elements of the Care Plan listed below.

    a. Targeted Case Management/Case Managment

    b. Peer Support Services

2. Services requiring a Treatment Plan: The following services will continue to require use of the Treatment Plan form for monitoring and review purposes. The following will also require the use of the Problem List unless otherwise specified.

    a. Therapeutic Behavioral Services (TBS)

    b. Intensive Home Based Services (IHBS)

    c. Intensive Care Coordination (ICC)

    d. Therapeutic Foster Care (TFC)

    e. Short Term Residential Therapeutic Programs (STRTP)

    f. Narcotic Treatment Programs (NTP) (*Do not require use of the Problem List)

    g. Social Rehabilitation Programs (including Crisis Residential)

    h. MHSA FSP (ISSP)

3. For clients with Medicare: According to Medicare Benefit Policy Manual, Chapter 6, Section 70.1, Treatment Plans must meet the following requirments: "..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 plan may be written within the progress note.

4. The time period for providers to complete an initial and subsequent Care Plans or Treatment Plans is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice. . Sacramento County considers it best practice to complete the assessment 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 or Treatment Plans not completed during these timelines will not result in recoupments

5. Discharge/Transition Plan – A discharge/transition plan should be developed when a beneficiary has achieved the goals of the Treatment Plan.
    a. This 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 Child Adolescent Needs and Strengths (CANS), / Adult Needs and Strengths (ANSA) needs scores and/or American Society of Addiction Medicine (ASAM)/ Substance Use Discorder (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

PROCEDURE:

Accuracy of the diagnoses and problem list are necessary for appropriate treatment services to a beneficiary, 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 Specialty Mental Health Services.

Consider relevant assessment screenings, such as the CANS, Pediatric Symptom Checklist (PSC-35), ANSA, and ASAM/ SUD Assessment when formulating the Care Plan or Treatment Plan and adding to the Problem List. For the Treatment Plan considerations may include considering needs, problem areas and strengths while co-creating objectives or factoring in ongoing planned interventions to address needs.

Problem List The Problem List Form in Avatar will be used when an issue has been identified by beneficiary and service provider. The Problem List Form in Avatar will also be used to identify when an issue has been resolved.
MHP and DMC-ODS will choose their respective Problem List from the options available and complete all areas.

Elements of the Care Plan in Progress Notes The narrative of the progress note for Targeted Case Management and Peer Services require the following minimum elements:

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 beneficiary;

2. Include activities/interventions such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary'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 beneficiary; and

4. Include development of a transition plan when a beneficiary 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.

Elements of the Treatment Plan Form For those services that require a Treatment Plan, continue to use the Treatment Plan form in the current EHRs, however, not all fields will be required.

1. The first Treatment Plan element, "Goals", may be broad or specific. Treatment should have a positive impact on the goals and ultimately improve the beneficiary's level of functioning.

2. The second element is "Interventions." Interventions are strategies and actions taken by the beneficiary, provider, and caregiver/significant support person(s) to meet the Treatment Plan objectives. Interventions must:

    a. Be consistent with the qualifying diagnosis.

b. Include interventions, regardless of funding, that will be used to meet the beneficiary identified goals.

3. Signature requirements on theTreatment Plan.

   a. Client signature is no longer required. Provider signature and credentials will continue to be required.
   b. The qualified staff's signature is required within a clinically appropriate timeframe. If required, as identified in the Avatar CWS Documentation Requirements Matrix, supervisor approval must also be obtained on all applicableTreatment Plans.

4. Discharge/Transition Plan – When the beneficiary has made progress toward their goals a discharge/transistion plan should be developed in the discharge plan section of the Treatment Plan. This should include 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 client is open to other BHS providers or discharge reports are provided to the Managed Care Plan (MCP) during step down transitions.

When creating a Care Plan in Progress Notes and/or a Treatment Plan in the Treatment Plan Form, use the Plan Development Code (98500) for MHP providers and Treatment Plan Code (Z501/Z601) for DMC-ODS Outpatient and Intensive Outpatient providers.

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
- BHIN # 22-019

RELATED POLICIES:

- QM 10-26 Core Assessment
- QM 01-07 Determination for Medical Necessity & Access to Speciality Mental Health Services
- Access 02-04 Authorization Requests
- SUPT 11-02 EHR and Documentation
- SUPT 03-01 Drug Medi-Cal Orgainzed 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		
	Substance Use Prevention and Treatment		
	Specific grant/specialty resource		

CONTACT INFORMATION:

- Quality Management Information
  QMInformation@saccounty.gov