Care Plan & Care Planning Explanation Sheet

Completed By:

- Licensed/Waivered Psychologist
- Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
- Licensed/Registered Professional Clinical Counselor**
- Physician (MD or DO)
- Licensed Psychiatric Technician
- Registered Nurse
- Clinical Trainee (with Co-signature)
- MHRS (with Co-signature)
- Peer Support Specialist (with Co-signature)

Clinical Trainees, Licensed Vocational Nurse, and MHRS, and Peer Support Specialists can complete care plans, with appropriate co-signature by one of the providers above. Co-signatures must be completed within timelines.

Compliance Requirements:

1. DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal Specialty Mental Health Services. The intent of this change is to affirm that care planning is an ongoing interactive component of service delivery rather than a one-time event*.

2. Required care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within the Electronic Health Record.

    a. It is recommended (but not required) that service lines who require a care plan utilize the *Interdisciplinary Treatment Plan* document in SmartCare.

3. The provider shall be able to produce and communicate 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 if requested.

4. Federal or state laws continue to require the following service lines to have care plans and/or specific care planning activities in place. All required elements of the Care Plan must be addressed as indicated in Enclosure 1a of BHIN 23-068:

    a. Community Health Worker (CHW)- A written plan of care is required for continued CHW services billed after twelve (12) units / six (6) hours of care per member in a single year from the initial date of service with the exception of services provided in the Emergency Department.

        - The plan of care or treatment plan is developed by one or more licensed providers that describe the needs for a Medi-Cal member that will be addressed by CHW.

- CHW may also draft a plan of care or treatment plan that identifies interventions for CHW services, which is then reviewed and approved by a licensed provider

b. Crisis Houses – A care plan must be completed within twenty- four (24) hours of admission and updated at least every seven (7) days.

- Care plans shall include at minimum the following elements: statement of specific treatment needs and goals, description of services to address identified needs, anticipated length of stay and method to evaluate achievement of goals. (9 CCR § 532.2)

c. TRTP/ RTP (Transitional Residential Treatment Program/ Residential Treatment Program)

- Must be completed within twenty-four (24) hours of admission
- Must be updated every thirty (30) days

d. Full-Service Partnership (FSP) Individual Services and Supports Plan (ISSP) - 9 CCR § 3620 requires an ISSP be developed for each client by the assigned Personal Service Coordinator/Case Manager. The ISSP should be developed with the client/family in collaboration with other agencies that have shared responsibility for service and/or supports to the client and client's family.

e. Intensive Care Coordination (ICC)– ICC services are considered TCM and may be documented in the manner noted in BHIN 23-068 (*Items 1-3*).

- Ongoing ICC care planning should occur during CFT meetings and be documented within the CFT progress notes. CFT meetings are required within sixty (60) days of assignment/ICC eligibility with updates to care plan as clinically appropriate, or at minimum every six (6) months.
- IHBS, TFC – DHCS will no longer enforce the use of a care plan, or specific care planning requirements, as part of monitoring compliance specific to IHBS or TFC, however children receiving these services are likely to have a care plan developed as part of ICC, which continues to require a care plan per Federal regulations.
- IHBS and TFC services, if provided, should be addressed as part of ICC care planning during CFT meetings. Documentation of IHBS and TFC care planning within CFT progress notes required for prior authorization.

f. Peer Support Services (PSS)– State requirement for care plan at start of services and updated as clinically appropriate.

g. Short-Term Residential Therapeutic Programs (STRTPs) – Initial care

plan completed within ten (10) days of admission date and reviewed every thirty (30) days.

- Documentation in the client record must indicate care plan has been reviewed with client and indicate if changes to plan or reviewed without revision.

- STRTP care plans shall include anticipated length of stay, specific behavioral goals for members and specific mental health interventions and services to assist client to accomplish goals and include transition goal(s) to support rapid and successful transition back to community based mental health care.

- Care plan must be signed by Licensed/waivered/registered professional or Head of Service.

h. Therapeutic Behavioral Services (TBS)– client plan must be completed prior to initial coaching session and updated every thirty (30) days.

- TBS care plan is required to address the following elements: targeted behaviors identified in the TBS assessment process, specific observable quantifiable goals tied to the targeted behaviors, objectives, interventions for each targeted behavior, transition plan.

- TBS plan updates should document any significant changes in youth or youth's environment, effectiveness of interventions and revisions to planned interventions, if applicable.

i. Targeted Case Management (TCM) – Federal requirement for development and periodic revision of specific care plan based on information collected through assessment that includes specific goals and action to address medical, social, educational, and other services needed by the client; includes active participation of the client and other identified supports, and action steps of provider to respond to client needs. (42 CFR § 440.169 (d)(2))

j. Medi-Care/ Medi-Medi - Requirements for Medicare and/or Medi-Medi members remain unchanged; CalAIM initiatives (BHIN 23-068) do not supersede CMS client plan requirements for Medicare members receiving Outpatient SMH services.

- Individualized Treatment Plan: Services must be prescribed by a physician and provided under an individualized written plan of treatment by a physician after any needed consultation with appropriate staff members.

- The plan must state the type, amount, frequency, and duration of services to be furnished for covered services provided by MD,

NP, PA, LCSW/LMFT/LPCC, the diagnosis and anticipated goals. (Only Medicare approved provider types such as MD/DO/LCSW/LMFT/LPCC/PA/NP can create a treatment plan.

- If the treatment plan is created by an LCSW/LMFT/LPCC/PA/NP, the treatment plan must be reviewed and co-signed by the MD/DO as regulations require that Medicare reimbursable services are prescribed by a physician)

- Please note that a care is not required if only a few brief services will be furnished.) (*CMS Publication 100-2, Medicare Benefit Policy Manual, Chapter 6, Section 70.1*)

*Prior Authorization timelines remain unchanged regardless of changes to client plan requirements.

5. CalMHSA Knowledge Base website Treatment Plans and Care Planning - 2023 CalMHSA provides information regarding the required care planning regulations for the different programs/service delivery lines and includes guidance on how/where to document care planning in the client's EHR.