Clinical Practice Guidelines Manual

Supporting Recovery through Person-Centered, Family Driven, Strengths-Based Mental Health Services & Supports for Title 9 Programs

Rev. September 18, 2020
County of Santa Clara Behavioral Health Services Department

In partnering with clients, families and communities to create culturally competent opportunities for Hope, Wellness & Recovery, the Behavioral Health Services Department (BHSD) is committed to serving, improving & making a difference in the lives of County of Santa Clara (CSC) residents diagnosed with mental illness. Recovery from mental illness is a realistic goal & the BHSD supports individuals and families in achieving this goal.

Our Vision

The public behavioral health system is successful in helping to ensure that all residents in need of public behavioral health services are:

- Physically and emotionally healthy happy and thriving
- In a safe and permanent living situation
- Part of a loving and supportive social network
- Involved in meaningful school, work activities
- Safe from harm from the environment or others

Our Mission

To assist individuals in our community affected by mental illness and serious emotional disturbance to achieve their hopes, dreams and quality of life goals. To accomplish this, services must be delivered in the least restrictive, non-stigmatizing, most accessible environment within a coordinated system of community and self-care, respectful of a person's family and loved ones, language, culture, ethnicity, gender and sexual identity.

Our Values

We believe without reservation:

- All people have the right to behavioral health and well being
- All people must be treated with fairness, respect and dignity in a culturally and linguistically competent way
- With effective treatment and support, recovery from mental illness is achievable
- Consumers will actively participate in their own recovery and treatment goal
- Consumers and their families will be at the center in development, delivery, implementation and evaluation of their treatment
- The system of care must have a structure and process for ensuring access to needed services for potential and current consumers
- All people must have access to the highest quality & most effective integrated services

Strategic Priorities

- Expand focus to include: promotion, prevention, early intervention, treatment and recovery support across life span
- Build capacity within key partners to assure mental health literacy integration with primary care, improved access to service
- Increase ethnic and cultural population access to engagement in services through new innovative strategies
- Increase community mental health knowledge and understanding to prevent problems, reduce stigma and assure access
Acknowledgements

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I: INTRODUCTION

Goal
This set of system standards has been developed to bring together the individual programs that make-up the County of Santa Clara, Behavioral Health Services Department, Mental Health Services network of county-operated and contracted programs around a uniform and integrated approach. These standards are intended to best serve the needs of Individuals and children/families and maximize their outcomes. Efficient use of available resources for these individuals, whether from Medi-Cal or other funding sources, including informal community resources is also an important part of our practice. Additional intended benefits include:

- A fundamental shift from a problem focused, provider/services-centered frame to a recovery oriented, person-centered, family-driven one
- Seamless transition when Individuals need to move from one program to another or to the community to their reclaimed life
- Assurance that services provided meet Individual and child/family needs and qualify for reimbursement
- Guidance to assure documentation and compliance audit standards do not conflict; rather support the highest level of effective service for individuals and their families

Philosophies and Principles
The system standards described in this document are informed and guided by a set of shared philosophies and principles derived from best practices care models such as Systems of Care, Recovery Model, and Wraparound to create transformational care planning methodologies and which are reflective of “Transformational Care Planning” (TCP) as developed by the California Institute for Behavioral Health Solutions (CIBHS) and based on the book Treatment Planning For Person-Centered Care (Adams & Grieder, 2005, 2014). These serve to unite individual programs and the agencies in which they operate to function as a dynamic whole with clients and their families at the center. These philosophies and principles state that:

Mental health system transformation for adult individuals and children/families must be based on a recovery oriented, person-centered/family-driven, strengths-based model that prioritizes what matters most to the Individuals and children/families and their life aspirations. In essence, this is because individuals and families know what works best for them and what their limitations are.

Unlike the experience of receiving various individual services, the individual’s or family’s experience is holistic. “Holistic” can be defined as “an alternative treatment system that focuses on the whole person rather than on specific diseases or disorders, and considers physical, emotional, social, environmental, and spiritual factors.”

- Individuals and families have a unique credibility and level of engagement that cannot be replicated by any aspect of the service system. They must be regarded as the primary experts on themselves and their children.
- Individuals, children, youth and their family/caregiver make the decisions about their own care and participate in developing and implementing strategies for behavioral health system improvement.
Besides being person-centered, family-driven, and culturally inclusive, services must be accountable at various levels. Following is a list of some general areas of accountability that apply to the standards in this guide:

- **To the Individual**: best practices, person-centered/family-driven practice, cultural inclusion, accepting what the individual and family knows, educating the individual or family on how the treatment process works
- **To self**: moral codes
- **To one’s profession**: ethical codes and standards of practice
- **To employer**: business code of ethics, work behavior
- **To licensing, regulatory bodies, and funding sources**: Community Care Licensing, Medical regulations, State and federal laws/regulations
- **To community**: public confidence that those receiving services will be treated professionally and safely.

### Service System

The standards delineated in this document address the day-to-day processes of outpatient mental health services, ranging from initial access through discharge, and so includes activities related to engagement, assessment, understanding, planning, interventions, and transitioning to other county services or community resources - and their inter-dependencies, as is represented in this simplified flow chart:

This simplified representation of the care process is intended to support system design and performance improvement. It is not intended to imply that an individual’s care process is linear or fully represented in this diagram. Detailed descriptions are contained in this guide.

### Structure of These Standards

Each of the standards associated with this service system are described in the structure below. The sections within this structure are addressed to capture the inherent complexity associated with achieving the goals, philosophies and principles stated above. These sections provide the detailed specifications for system design and staff performance to assure every individual and child/family service encounter is beneficial.

**Action and Outcome**: A key aim of these descriptions is to clarify how the activity functions in the overall system, including how it is informed by steps that precede it as well as those that follow it.

**Standards of Practice**: Practices in this section are delineated in the following categories:

- **Clinical Practices**: Specific clinical techniques, approaches, or evidence-based practices that should be applied are described in this section. Documentation Requirements that are applicable to Clinical Practices are integrated into this part of each section.
• **Processes to Support Engagement:** A key feature of the County’s system design is a focus on individual and family engagement. This high degree of attention to engagement is based on the recognition that level of service effectiveness is highly correlated to level of individual and family engagement - and efforts to gain and enhance engagement start with initial contact and continues throughout services.

• **Frequency, Timing and Documentation:** The timing for this activity, as is relates to other activities and in terms of what triggers it, as well as the expected frequency of the activity are described in this section. Documentation Requirements applicable to each section that are not included in Clinical Practices are detailed here.

Throughout this section, those standards that also serve as “Quality Indicators” are identified as such. The actual indicators and review tools are provided. These tools are used to measure the level or degree of achievement of key standards. Indicators delineated on these tools should not be confused with compliance measures. However, in some cases, they support regulatory compliance; in some they exceed regulatory requirements; and in other cases they fall outside of regulatory concerns (e.g., do not have a regulatory-related requirement).

**Adoption & Application of Practice Guidelines for End Users**

The development and utility of a practice standards manual is supported throughout systems, including the Code of Federal Regulations (Title 42, Chapter IV, Subchapter C, Part 438.236 - “Adoption of practice guidelines: Each MCO,...each PIHP and PAHP adopts practice guidelines that...Are based on valid and reliable clinical evidence or a consensus of providers in the particular field...”). The guidelines were developed in partnership between The County of Santa Clara’s Behavioral Health Services Department (CSCBHSD) providers, Consumer Affairs, Quality Assurance (QA), and Clinical Standards staff. The manual is reviewed and updated periodically, as appropriate. It is published and posted on the CSCBHSD Quality Assurance [website](#), along with a log of updates, which is available to all providers and the public. Providers are notified of updates via e-mail and in workgroup meetings.

The Practice Guidelines Manual is intended to support the following uses and associated end-users for application in:

• Auditing and Documentation Compliance (Quality Assurance)
• Clinical Supervision, Staff Coaching, Professional Development and Training
• Consumers (Consumer Advisory Council)
• Contracting and Contract Management
• New Hire Training and Orientation
• Performance Management/Quality Improvement
• System Design
• Utilization Management

This manual is to be used as a reference guide and is not a definitive single source of information regarding chart documentation requirements. The following CSCBHSD programs and community-based agency references should be informed by these standards:

• California Code of Regulations (CCR), Title 9
• California Department of Health Care Services (DHCS) letter’s/notices
• Documentation Standards (DHCS & CSCBHSD requirements)
• Employee Job Descriptions and Performance Evaluations
• Person-Directed Planning Clinical Record Review
• Provider Contracts
• County of Santa Clara Behavioral Health Department Policy & Procedures, directives, and/or memos
• Quality Assurance & Clinical Standards interpretation and determination of standards and practices
• Supervisor Tools and Competency Lists
• System Dashboard of Performance Measures
• Training Programs

In all cases, the reader should defer to California Code of Regulations, Title 9, State and Federal Regulations.
II: CLINICAL SUPERVISION

Action and Outcome

Improving the health and wellness of the Individuals/families we serve is our system’s primary purpose. Clinical supervision is an essential practice that supports providers at all levels and improve the quality of care and services.

CSCBHSD has developed a Clinical Supervision Recommendations and Program to improve the quality of our clinical supervision practices. Included in this program are best practice recommendations to ensure the appropriate skill level of supervisors, frequency, and content of clinical supervision. Practicing to these standards can enhance the practitioner’s delivery of quality care from the first point of contact throughout the continuum of care by:

- Receiving regular, structured supervision grounded in best practices
- Enhancing the supervisee’s skills, knowledge and professional development
- Promoting recovery-oriented services in culturally relevant, person-centered and family-driven ways
- Promoting healthy morale
- More effective client movement through levels of care
- Promoting fidelity to Evidenced Based Practices (EBPs)
- Adhering to agency, licensing, and accrediting requirements
- Monitoring legal and ethical issues to reduce liability
- Increasing staff retention
- Developing and promoting a learning culture

Clinical Supervision Defined

Clinical supervision is a broad term which encompasses different principles, activities, disciplines and areas of practice. It involves regular, protected time for facilitated, in depth reflection on practice. Clinical supervision is applicable for all staff involved in the delivery of mental health services regardless of their experience or professional background. CSCBHSD has adopted the following definition from Falender & Shafranske, who are leading experts in the field of clinical supervision:

“Supervision” is a distinct professional activity:

- In which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process
- That involves observation, evaluation, feedback, facilitation of supervisee self-assessment, and acquisition of knowledge and skills by instruction, modeling, and mutual problem-solving.
- That builds on the recognition of the strengths and talents of the supervisee and encourages self-efficacy.
- That is conducted in a competent manner in which ethical standards, legal prescriptions, and professional practices are used to promote and protect the welfare of the client, the profession, and society at large (Falender & Shafranske, 2004, p. 3).
**Anticipated Outcomes**

It is anticipated that by valuing clinical supervision at all levels within an organization:

- Management will be more attentive to hiring practices of supervisors
- Supervisors will be formally trained in the delivery of clinical supervision and participate in ongoing consultation groups
- Supervisors will be assigned a manageable number of staff/supervisees

In addition, by maintaining consistent, high quality clinical supervision sessions with practitioners, implementing clinical supervision standards, and training supervisors in advanced practice the following outcomes are anticipated of practitioners:

- Experience enhanced professional growth and development
- Be supported on best practices in their respective areas of service
- Be more mindful of agency, licensing, ethical, and state requirements
- Provide more effective, high quality care to consumers
- Be given feedback & gain insight to their professional competency

**Standards of Practice**

**Recommended Core Practice Skills for Clinical Supervisors**

- **Knowledge base**: Comprehends and applies a variety of individual and systemic therapeutic models and demonstrates their application in individual and/or group supervision
- **Supervisory Relationship**: Develops and maintains a working alliance in order to enhance and maximize client care and professional development. Supervisor understands the importance of parallel processes
- **Contextual Factors**: Knowledgeable of factors affecting the supervisee in the context of their clinical work with clients from diverse sociopolitical backgrounds. Supervision addresses the sensitivity and skills supervisees need to implement adaptations to practice when issues of difference are present
- **Legal/Ethical/Regulatory Issues**: Understands and applies the respective professional, discipline, legal and ethical standards, standards of the agency of employment, and relevant mental health county, state and federal laws/mandates
- **Standards & Work Management**: Manage and model responsibilities and tasks of work assignment within agency timelines and expectations

**Supervision methods**

A combination of clinical supervision methods is recommended including, but not limited to:

- Individual
- Group
- Audio/video tapes
- Documentation review
- Live supervision
- Process recordings
- Role play
**Supervisor/supervisee ratio**

Agencies are recommended to maintain a workflow that is manageable for supervisors by attending to the ratio of supervisors to supervisees. The numbers of supervisees assigned to a supervisor should be tied to licensure regulations, level of expertise and experience, years of professional practice, comfort level, complexity and intensity of services, qualifications, etc. Best practice recommends a ratio of no more than 1:8.

**Processes to Support Engagement**

Supervision practices and processes that support a working alliance and engagement may include:

- Ongoing agreement about clear roles and expectations for the supervisory relationship
- Confidentiality, safety and transparency
- Adapting supervision processes to the supervisee’s progress in professional growth and development
- Identifying and managing transference and counter transference issues
- Establishing and maintaining professional boundaries
- Awareness of the sociopolitical context within which the supervision is conducted
- Creation of a climate in which honest feedback is the norm (both supportive and challenging)
- Providing formative and summative feedback
- Understanding and accommodating power differentials and dual roles of the supervisor and supervisee
- Ability to inspire and motivate
- Ability to facilitate reflection

**Frequency, Timing, Documentation**

Supervisors should provide consistent, scheduled, and structured supervision. Recommendations include the following minimum requirements:

- Unlicensed staff on licensure track receive supervision in accordance to their licensure board requirements
- Licensed staff receive one unit* of supervision 2 times/month
- Paraprofessionals and other practitioners receive one unit* of supervision weekly

* One unit of supervision = 1 hour of individual or 2 hours of group supervision

**Best practices in recording clinical supervision:**

**Minimum standards:**

1. A completed supervision agreement/contract signed by the supervisor and practitioner at the commencement of the supervisory relationship
2. A continuing record maintained by the supervisor of the supervisee’s attendance at clinical supervision

Additional standards:

1. Time and date of the session
2. Name of the practitioner
3. Outline/summary of the cases/issues discussed with special attention to legal, ethical, and risk management
4. Outcomes and action plan

Scope of Practice

Those qualified to provide clinical supervision will vary depending on the provider/supervisee’s role, setting, credential, etc.

- Applicable regulatory board or agency supervision qualification requirements must always be met.
III: MEDICAL NECESSITY, RECOVERY & THE GOLDEN THREAD

Action and Outcome

Medical necessity criteria must be met for Medi-Cal reimbursement of specialty mental health services. This criterion, detailed below, includes three elements: Diagnosis, Impairment, and Interventions. The diagnosis and impairment criteria are established in the assessment process and documented in assessment reports (i.e., initial, update, etc.) Intervention criteria is established in the Recovery/Care plans. All three medical necessity criteria must be consistent with each other. The provided services/interventions, care plan goals, and progress notes must, also, be consistent with the medical necessity criteria established in the record.

Recovery refers to the progress one makes in improving their life. The long term goal of recovery is for the Individuals and families we serve to have a life in the community that is satisfying with meaning and purpose from the perspective of the Individual/family. Progress will vary depending on the Individual’s goals, strengths, and how much their life is impacted by their mental health condition. Some may make small incremental improvements over longer periods of time and others may make larger improvements that take less time. Our role is to facilitate and support this progress.

- Recovery and a severe mental health disability are not mutually exclusive. People can and do have satisfying meaningful lives and a serious mental health disability.
- Everyone experiences the joy and pride of meaningful roles, success, accomplishment and meaningful connection to others.
- Recovery is a process and journey. Someone who makes progress toward meaningful life improvements, no matter how small or incremental, is in recovery.
- The role of practitioners and the behavioral health system is to facilitate this progress.

The Golden Thread refers to the link or connection that stitches together medical necessity, Recovery/Care Plan, services we provide, and progress notes.

Standards of Practice

Clinical Practice: Medical Necessity [Criteria CCR. Title 9 (1830.205, 1830.210)]

1. The client must have a current qualifying mental health diagnosis from DSM 5/ICD-10
2. Experience an impairment in functioning as a result of their mental health condition that meets one of the following criteria:
   a. A significant impairment in an important area of life functioning (e.g., health, daily activities, social relationships, and/or living arrangements)
   b. A reasonable probability of significant deterioration in an important area of life functioning
   c. For a child (a person under the age of 21 years), a reasonable probability that the child will not progress developmentally as individually appropriate
3. Must meet each of the intervention criteria listed below:
   a. Focus of the proposed intervention(s) must address the identified functioning impairment criteria listed above under item 2
   b. The proposed intervention will do at least one of the following:
1) Significantly diminish the impairment  
2) Prevent significant deterioration in an important area of life functioning  
3) Allow a child to progress developmentally as individually appropriate  
   c. The condition would not be responsive to physical health care based treatment  

The impairment and intervention criteria are in alignment with recovery principles because their focus is on real life functioning improvement.

**Processes to Support Engagement**

According to Friedli (2009), “Although definitions vary, positive mental health is generally seen as including: emotion (affect/feeling), cognition (perception, thinking, reasoning), social functioning (relations with others and society), and coherence (sense of meaning and purpose in life).” In order to provide great services to others, it’s important to understand recovery and resiliency. These are the foundational elements of recovery, according to SAMHSA, which directly relate to functioning and impairment criteria for medical necessity.

<table>
<thead>
<tr>
<th>Dimension that supports a life in recovery</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Make informed, healthy choices that support physical and emotional wellbeing (self-care, exercise, diet, etc.)</td>
</tr>
<tr>
<td>Home</td>
<td>A safe and stable place to live</td>
</tr>
<tr>
<td>Purpose</td>
<td>Connection and participation in something meaningful (activities, volunteering, creativity, supporting family/others…)</td>
</tr>
<tr>
<td>Community</td>
<td>Supportive relationships and social connections/networks</td>
</tr>
</tbody>
</table>

Establishing the impairment criteria for medical necessity is an opportunity to engage individuals/families about their life and learn from them how it is being impacted by their mental health condition and what areas are most important to them.

The following person-centered strategies may help engagement when reviewing each important life area (Health, Daily Activities, Social Relationships/Community, Living Arrangements/Home) with the individual/family:

- How do they feel about that part of their life? What would they like to see change?  
- Are there ways they would like it to be better?  
- Was it better in the past?  
- How did they make it better then?  
- How do they think they could make it better now?
Aspects of the Individual/family’s life learned by these conversations can guide treatment/services that best fit with an Individual/family while enhancing collaboration, engagement, and the alliance.

Additionally, as part of our collaboration through the Greater Bay Area, CSCBHSD has adopted the core principals of Trauma Transformed, or T². These principles provide reflection into our system as we strive to become more trauma-informed in our day-to-day practices, which impact those around us. The values and principles include:

1. **Understanding trauma and stress (Trauma Competence):** Without understanding trauma, we are more likely to adopt behaviors and beliefs that are negative.
   a. Trauma - We understand that trauma is common, but experienced uniquely due to its many variations in form and impact.
   b. Stress - We understand that optimal levels of positive stress can be healthy, but that chronic or extreme stress has damaging effects.
   c. Reactions - We understand that many trauma reactions are adaptive, but that some resulting behaviors and beliefs may impede recovery and wellness.
   d. Recovery - We understand that trauma can be overcome and unhealthy. However, when we understand trauma and stress we can act compassionately and take well-informed steps toward wellness.

2. **Compassion and dependability (Trustworthiness):** Trauma is overwhelming and can leave us feeling isolated or betrayed, which may make it difficult to trust others and receive support. However, when we experience compassionate and dependable relationships, we reestablish trusting connections with others that foster mutual wellness.
   a. Compassion - We strive to act compassionately across our interactions with others through the genuine expression of concern and support.
   b. Relationships - We value and seek to develop secure and dependable relationships characterized by mutual respect and attunement.
   c. Communication - We promote dependability and create trust by communicating in ways that are clear, inclusive, and useful to others.

3. **Safety and stability (Physical and Emotional Safety):** Trauma unpredictably violates our physical, social, and emotional safety resulting in a sense of threat and need to manage risks. Increasing stability in our daily lives and having these core safety needs met can minimize our stress reactions and allow us to focus our resources on wellness.
   a. Stability - We minimize unnecessary changes and, when changes are necessary, provide sufficient notice and preparation.
   b. Physical - We create environments that are physically safe, accessible, clean, and comfortable.
   c. Social-Emotional - We maintain healthy interpersonal boundaries and manage conflict appropriately in our relationships with others.

4. **Collaboration and empowerment (Empowerment, Choice & Collaboration):** Trauma involves a loss of power and control that makes us feel helpless. However, when we are prepared for and given real opportunities to make choices for ourselves and our care, we feel empowered and can promote our own wellness.
a. Empowerment - We recognize the value of personal agency and understand how it supports recovery and overall wellness.
b. Preparation - We proactively provide information and support the development of skills that are necessary for the effective empowerment of others.
c. Opportunities - We regularly offer others opportunities to make decisions and choices that have a meaningful impact on their lives.

5. Cultural humility and responsiveness (Cultural Populations & Trauma): We come from diverse social and cultural groups that may experience and react to trauma differently. When we are open to understanding these differences and respond to them sensitively we make each other feel understood and wellness is enhanced.
   a. Differences - We demonstrate knowledge of how specific social and cultural groups may experience, react to, and recover from trauma differently.
   b. Humility - We are proactive in respectfully seeking information and learning about differences between social and cultural groups.
   c. Responsiveness - We have and can easily access support and resources for sensitively meeting the unique social and cultural needs of others.

6. Resilience and recovery (Commitment to Trauma-informed Philosophy domain):
   Trauma can have a long-lasting and broad impact on our lives that may create a feeling of hopelessness. Yet, when we focus on our strengths and clear steps we can take toward wellness we are more likely to be resilient and recover.
   a. Path - We recognize the value of instilling hope by seeking to develop a clear path towards wellness that addresses stress and trauma.
   b. Strengths - We proactively identify and apply strengths to promote wellness and growth, rather than focusing singularly on symptom reduction.
   c. Practices - We are aware of and have access to effective treatments, skills, and personal practices that support recovery and resiliency.

It is important to remember that facilitating life improvements for an Individual/family often leads to a place where medical necessity is no longer met. This is good and is the best outcome as transition into the community is the gold standard and supports hope and recovery! To learn more about County of Santa Clara’s efforts in being more trauma informed, please refer to our website.

**Frequency, Timing and Documentation**

- Medical Necessity is first established during the initial assessment process and documented in the assessment report.
- It should be monitored regularly to make sure it continues to be met and is consistent with the treatment provided.
- Review medical necessity during the course of treatment anytime there is a change in symptoms, functioning, or Care Plan goals and interventions

**QA Tips:**

- If the Short-Term Goal on the Care Plan addresses a life improvement consistent with currently established impairment criteria, the intervention/services we provide supports achievement of that Short-Term Goal, and we reflect the progress in the progress note, we are using the golden thread.
• All interventions/services provided and documented on the Care Plan must address the Individual/family’s functional impairments (difficulties) regardless of service mode (also known as treatment category), e.g., therapy, case management, rehab counseling, etc.

• Cloning Risk: Whenever information for one client is copied to populate forms/documents of another client, medical necessity is lost. Even clients with the same diagnosis will usually have differences in symptoms and functioning impairments.
  o Medical Record Cloning (Jurisdiction 1 Part B)
    ▪ When documentation is worded exactly like or similar to previous entries, the documentation is referred to as cloned documentation.
    ▪ Whether the cloned documentation is handwritten, the result of pre-printed template, or use or Electronic Health Records, cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.
    ▪ It would not be expected that every patient had the same exact problem, symptoms, and required the exact same treatment. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information for each unique patient.
    ▪ Documentation exactly the same from patient to patient is considered cloned and often occurs when services have a specific set of limited or select criteria. Cloned documentation lacks the patient specific information necessary to support services rendered to each individual patient.
IV: ASSESSMENT

Action and Outcome

Assessment is a process of collecting data from the many realms of an Individual’s life in order to make informed decisions about supports and services that will benefit an Individual and family. This process must be comprehensive enough to inform a wide range of treatment decisions, including those related to safety planning, intensity and frequency of services, types of interventions used, and even the timing of an Individual’s transition away from formal services.

The CCR Title 9 definition of “Assessment” is:

“Assessment” means a service activity designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary’s clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures. (CCR Title 9 Division 1, 1810.204)

Assessment first occurs at the onset of services, resulting in the creation of a formal written document. It also occurs on an ongoing basis throughout the course of treatment, as the Individual and provider work together to evaluate progress and make the adjustments needed to arrive at the Individual’s stated goals.

In general, indicators of an effective person-centered assessment process include:

- Focuses on improving recovery, wellness & resiliency
- Sets the stage for building on strengths
- Demonstration of cultural sensitivity and inclusiveness
- Development of relationship and therapeutic alliance
- Enhanced Individuals’ and family/supports’ engagement
- Establishment of a clinical formulation
- Information gathered is comprehensive and accurate to understand the Individual’s needs and desires/hopes to determine most appropriate services option(s)
- Individual and family feel comfortable and safe disclosing thorough information, and that they feel they are in an equal, trusted partnership with the provider

Standards of Practice

Clinical Practices: Assessments should be comprehensive and collaborative. Sources of information for assessments could include Individual, family, school, community connections, previous treatment providers and other sources. Assessments include standardized tools that are updated periodically over the course of the Individual and family/natural support’s involvement in services. This consistent practice will inform the Individual, family, and the provider about the progress being made and need for adjustments and changes in services. In County of Santa Clara, use of the MORS and/or DLA-20 (for adult Individuals) and CANS (for children and
youths) can serve that purpose and are required. However, other standardized tools may be required for additional or more specific measurement where appropriate including psychological testing.

California DHCS denotes assessment criteria to include, but is not limited to:

- Presenting Problem
- Relevant conditions and psychosocial factors affecting the Individual's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma
- Mental Health History
- Medical History
- Medications
- Substance Exposure/Substance Use
- Cultural Factors
- Client Strengths
- Risks
- A mental status examination
- A complete diagnosis from the most current DSM consistent with the above data
- Additional clarifying formulation information, as needed

Those included on the BHSD Initial & Update Mental Health Assessment forms are discussed below. CSC’s Mental Health Assessments do provide some prompts to guide you, but should not limit or restrict you from entering pertinent assessment data. Some information gathered may overlap across domains; it is not necessary to repeat information if it is already noted in another section.

**Presenting Problems/Obstacles**

Presenting problems identify an Individual/family’s reason(s) for coming to or continuing mental health services, their current mental health symptoms, behaviors, functional impairments, complicating factors (e.g., co-occurring disorders, environmental stressors, etc.) and the impact on their life. This is where medical necessity is established. Person-centered and recovery oriented assessment processes include:

- What are the most important things in the Individual/family’s life they would like to be different?
- What do they think is keeping them from that?
- What are their ideas about how we can help?
- How do they understand their symptoms, functioning difficulties, and other conditions affecting their lives?
- How does it interfere with their goals/aspirations?
- What has helped them in the past and how are they coping with them now?

Mental health symptoms documented in this assessment domain should include onset, frequency, intensity, and environmental factors. Significant impairment(s) resulting from the mental health condition show how the mental health condition is impacting their life. Impairments refer to what the Individual has difficulty doing or accessing and how that interferes with their recovery life areas of health, social supports, daily activities and meaningful roles, and living environment.
The symptoms and impairments identified here must support the mental health diagnosis being treated. Co-occurring or other mental health and substance diagnoses should also be supported by symptoms and impairments identified under presenting problems. Clinical judgment regarding symptoms, behaviors, and impairments should always consider cultural norms. Learning about and a consistent focus on what is most important to the Individual/family can facilitate person-centered/family driven care and reveal a pathway to their recovery.

A note on a person’s Motivation for Change: An important component of any comprehensive assessment should include exploration of an Individual’s and his or her natural support systems readiness to make needed changes. Because many Individuals in the public mental health system are referred by someone else (a probation officer, social worker, homeless outreach worker, teacher, etc.), it is critical that providers recognize this and assess its impact on the treatment process. The diagram to the right shows one popular model for thinking about the change process. For Individuals who did not refer themselves for treatment, it is important to include the referring party in the assessment process as much as possible, in order to clarify external motivators to change. In addition, motivational interviewing is a best practice that has been implemented in County of Santa Clara and can be used to help Individuals and/or families identify their own reasons for participating in treatment. Please see Appendix D for a table on Prochaska and DiClemente’s Stages of Change Model with intervention strategies for each stage.

Mental Health History

Learning about what an Individual/family experienced in previous treatment can be very helpful in informing and planning current treatment/services. The most useful information from a person-centered perspective is What was helpful? And What was not helpful?

An up to date mental health history includes previous treatment dates and services, providers, diagnoses, therapeutic interventions and responses, and inpatient admissions. If possible, include other sources of clinical data, mental health records, and relevant psychological testing or consultation reports.

Cultural Factors

A culturally sensitive assessment takes into consideration all the important cultural variables that affect the daily life of the Individual, family, and natural support system. It also focuses on tackling the barriers to effective communication with Individuals and families from a variety of cultural backgrounds. Gaining an understanding of the Individual and family’s worldview and view of themselves are key components to conducting a culturally sensitive assessment. This also enhances and strengthens their engagement and the therapeutic alliance in person-centered/family-driven practice.

Providers must quickly identify any language needs within the Individual/family or natural support system, and secure the resources to provide services in the appropriate language. Service providers who do not speak the language of an Individual or family must recommend transfer of care to a provider who is fluent in that language wherever possible. As a last
resort, a qualified third party translator may be used. Individual and family preferences must always be considered when making efforts to accommodate language needs.

Along with ethnicity and age, areas to consider in developing better cultural understanding and sensitivity include:

- Acculturation and generational and/or identity conflicts
- Beliefs about mental health and substance abuse including any experience of shame and stigma
- Beliefs, attitudes, and experience related to gender
- Co-cultures such as gang, drug, etc.
- Ethnicity, gender, sexual orientation, religion or spiritual beliefs and practices (including any discrimination experienced or related to)
- Education/special needs
- Family composition, relational roles, dynamics and power differentials
- How they understand and experience their symptoms
- Identity - What is their sense of self and place in society
- Immigration - experience, history, and any current impact
- Impact of socioeconomic status
- Language
- Preferences for linkage to community resources
- Preferences/comfort level regarding culture of the provider
- Sexual orientation and how that affects their identity and experience within their cultural context
- Spirituality/Religion: Importance, practices, community, satisfaction, etc.
- Trauma experience and exposure

This is not intended to be a complete list of cultural factors, but does provide a starting point and some important things to consider. Remember that while a given culture may have common norms, tendencies, etc., significant variations occur within all cultures and it is best to never make assumptions.

Finally, as the provider you should always be reflective with regards to how you are experiencing an Individual and family’s culture and be attuned to any bias or other negative responses you may be experiencing. Consultation with colleagues and clinical supervisors around this is crucial.

**Strengths**

Strengths can be utilized to achieve identified plan goals and support one’s overall process of recovery. Emphasizing strengths, rather than deficits and problems, creates opportunity to see possibilities, options, and promotes change (Adams & Grieder 2005). A basic inventory of strengths should, at minimum, include consideration of:

- Abilities, talents, competencies, and accomplishments in any range of settings.
- Circumstances at home, school, work or the community that worked well in the past.
- Family members, relatives, friends, and other “natural supports” (both formal and informal relationships) within the community.
- Interests, hopes, dreams, aspirations, and motivation.
- Resiliency
- Resources and assets; monetary/economic; social, and interpersonal
• Unique individual attributes (physical, psychological, performance capabilities, sense of humor, etc.)
• Values and traditions

Additionally, assessment/outcome measures, such as CANS, MORS, and DLA-20 can be extremely useful in identifying strengths.

Psychosocial History & Primary Life Domains

Learning about an Individual’s psychosocial history can help broaden understanding and appreciation for the individual and their current circumstances. It can also help identify themes, patterns, risk/protective factors, resiliency, and strengths. A psychosocial history examines family and social history from birth to present and informs multiple life domains. For example, an Individual may exhibit different kinds of behavior in various circumstances or settings. An Individual may have difficulty at home, but function well at work or school. What the Individual/family experience related to different domains can broaden the understanding of the Individual, strengthen the alliance, and inform their care plan.

Below are several life domains that a psychosocial history can inform. Some of these domains are described in more detail elsewhere in this section.

• Childhood
• Cultural and spiritual
• Developmental history
• Education/vocational
• Family
• Financial needs
• Legal issues
• Living Situation
• Natural supports
• Physical needs/health status
• Pregnant and parenting teens
• Risk factors and protective factors
• Socialization, including friends and significant others

Developmental Stages and History: Assessment and the entire planning and service delivery process must be informed by an understanding of the Individual’s stage of development including prenatal and perinatal events. This is important for children and youth, who rapidly grow and change, reach milestones, tackle developmental tasks, and learn age-appropriate skills along the way.

It can also be helpful to consider the developmental history as well as what stage of life an adult is facing. While change may happen more slowly in adulthood, a young, single adult working his or her first job faces dramatically different challenges than an older adult whose children are grown. It is also important to remember that while an Individual’s stage of development often correlates to his or her chronological age, in many circumstances it does not. Substance use and cognitive disability are just two examples of factors that may delay an individual’s development at any age.
An assessment should consider how an Individual’s age and stage of development may relate to his or her reasons for seeking services, and the motivation of the family or natural support system for participating in the process.

**Medical History**

Person-centered family-driven practice goes beyond just what the medical condition is or was and explores the Individual, family/natural support system’s experience with it. Always identify the Individual/families’ primary care physician (PCP), cultural healer, and/or other practices they have used to address their medical and health needs. If they are not connected to a PCP or other resources, a referral or other efforts should be made to help them establish an appropriate resource.

Relevant general medical conditions reported by the Individual, child/youth or caregiver should be identified and updated as appropriate. Individual, family/supports’ report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities must be clearly documented. For children and adolescents, the history must include prenatal and perinatal events and relevant developmental history.

Relevant lab tests can be included. Medical and health status can also include diet and nutrition, dental, hearing, and eye care needs. (Note: if the assessing clinician is not aware of the potential relevance of the medical condition to the management of the Individual’s mental health condition, please consult a physician.)

**Medications**

A person-centered/family-driven approach focuses on the Individual/family’s experience with the medication taking into consideration their cultural context.

- What it is like for them?
- How it helps them?
- What they do they think about taking medication?

*Remember: If an individual does not want to take medications or has a history of not taking recommended medications, reasons for that should be explored, considered, and respected.*

Information about medications should include:

- Currently prescribed medications (including psychotropic), dosages of each, prescription dates and refills
- All over-the-counter, herbal, and/or alternative remedies
- A history of medication/remedy use
- Documentation of informed consent for medications prescribed by your clinic or agency in the chart

For the current County of Santa Clara Behavioral Health Department Medication Practice Guidelines [click here](#).

**Substance Use History**

Many individuals coming into the mental health system have current substance/alcohol use related difficulties. In person-centered/family driven practice it is important to understand:

- How the Individual or family experiences the substance use
- How it helps or harms them
• What it means to them
• How it influences their life and their mental health

It is important to consider how substance use and mental health conditions can interact with each other. Some individuals will use substances to remedy mental health symptoms. Use of some substances will present symptoms that look like a mental health condition. It can be difficult to assess which condition is primary or if they are co-occurring. You can ask if there were any periods in which the individual did not use substances and how they were doing during those times. If things were going well it will point to a substance use issue. If they were doing poorly or worse, it may point to a mental health condition.

It is important to take enough time to understand the issues around substance use, how they are interfering with their life goals, and what additional services may be beneficial. A mental health practitioner can diagnose a secondary substance use disorder and address those issues in service to improving their mental health condition. A referral to Substance Use Treatment Services (SUTS) or a co-occurring provider may be warranted.

A substance use history should review alcohol & other substance use including, but not limited to, past & present use of tobacco/nicotine, alcohol, and caffeine, as well as illicit, prescribed & over-the-counter drugs.

**Risk & Protective Factors**

Assessments must also identify important risk and protective factors in the individual/family’s life, as these can increase or decrease their risk of developing problems such as aggressive behavior, self-injury, or substance use. Safety is always a primary consideration when evaluating risk and protective factors. Risk and protective factors can be considered along these five domains:

• Individual
• Family
• School/work
• Peer group
• Community

Risk factors include such things as teen parenthood, gun ownership, history of abuse/trauma, drug use and family violence, just to name a few. Protective factors include such things as engagement in spiritual activities, having problem-solving skills, having good relationships with family members, and resiliency.

**Mental Status Exam**

A mental status exam is intended to evaluate current aspects of an Individual’s mental state and functioning. Many of these aspects are observed during the course of the interview or session and some are obtained by questioning. A mental status exam can help broaden understanding of an Individual and their functioning challenges and strengths.

It is important to consider the Individual’s cultural context when applying clinical judgment to mental status items.
Diagnosis & Medical Necessity Impairment Criteria

Medical necessity is identified and documented throughout the Individual and their family/natural support’s involvement with the mental health system, from assessment to service plans to progress notes. Medical necessity criteria identifies the mental health needs and functional impairments that need to be addressed by mental health interventions. The service provider should observe and document, within their scope of practice (appendix B), evidence of medical necessity. Documentation of diagnosis, symptoms, and functional impairments as related to the diagnosed condition(s) are key to providing evidence of medical necessity.

For more on Medical Necessity, please see section titled, “Medical Necessity, The Golden Thread, and Recovery (Section III).”

- Note regarding Diagnosis: The diagnosis section may only be completed by an LPHA. The included (qualifying) diagnosis must be established with the use of the DSM5 manual and cross walked to an ICD10 code. If there is more than one option within the ICD10, the clinician will need to determine which code best correlates with the DSM5 diagnosis.

Processes to Support Engagement

The initial clinical assessment process begins at our first contact with the Individual and family. It is often the first time we are meeting them, and they are meeting us. This is an opportunity to begin building a trusting and helpful relationship. While the forms and document requirements are important, we should do our best to focus our attention on the Individual and family.

Most assessment information can be gathered in a conversational approach with the Individual and family where they are allowed to lead the direction. This is a great way of finding out what is most important to them initially and it is helpful in developing a good person-centered/family-driven relationship. It is best to be mindful of over directing and being too rigid in following any particular form.

Often, a friendly orientation to the setting, services, and something about you can be a good icebreaker and help ease the Individual and family’s anxiety, but you should ask them if that is something they would like to know more about, first. “How can I help?”, and “What would you like to get out of services here?” can be good places to start. It is best to get to their desires, dreams, and goals early in the engagement process. That will lead nicely into the strengths that will help them reach their goals. This opens possibilities and hope for the Individual and goes a long way to getting the relationship off to a good person-centered/family-driven start.

Frequency, Timing, Documentation

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency, Timeframe</th>
<th>Documentation</th>
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<tbody>
<tr>
<td>Initial Assessment</td>
<td>The initial mental health assessment is required for all Individuals who are new to the outpatient mental health system. If the Individual is expected to be in long-term treatment, the initial assessment shall be</td>
<td>• Initial Assessment</td>
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<td></td>
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<td>• Progress Note</td>
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<tr>
<td>Activity</td>
<td>Frequency, Timeframe</td>
<td>Documentation</td>
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<td>completed within 60 calendar days from the date their case was opened to an agency.</td>
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<tr>
<td>Updated Assessment</td>
<td>An Update Assessment is to be completed no later than every two (2) years (no later than the same calendar month as the LPHA signature).</td>
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<td></td>
<td>• <strong>This is a minimum standard.</strong> It does not prevent continuous assessment/progress of Individuals/family’s needs and levels of care.</td>
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<td></td>
<td>• Addendums or any updated information can and should be documented in the Clinical Update Assessment form and progress notes prior to the deadline for the update.</td>
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<tr>
<td>Transfer of Program</td>
<td>Definition of Transfer: Existing individuals who are currently opened and are transitioning to a new program/agency without disruption to their treatment.</td>
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<td>If an Individual transfers to a new program or is added to a new program, the clinician has the following options:</td>
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<td>• To complete a new assessment within 60 calendar days, or</td>
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<td></td>
<td>• Accept the prior assessment, if satisfactory, if it was completed within the past two (2) years. The transferred assessment must be updated within two (2) years of that LPHA signature.</td>
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<td>• A progress note should be written indicating the assessment was reviewed &amp; approved by the receiving agency.</td>
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<td>• Accept the prior assessment, but if there are sections missing or unsatisfactory the clinician must update and complete these sections within 60 calendar days in a progress note and on a MH assessment update form.</td>
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<td></td>
<td>• Diagnosis should always be reevaluated to make sure it is still consistent with needs and functional impairments.</td>
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<td></td>
<td><strong>NOTE:</strong> It is a good idea to review the narrative summary and amend if needed.</td>
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<tr>
<td>Scope of Practice</td>
<td>“The diagnosis, MSE, medication history, and assessment of relevant conditions and psychosocial factors affecting a beneficiary’s physical and mental health must be completed by a provider, operating in his/her scope of practice under California State law,</td>
<td></td>
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</table>
### Activity | Frequency, Timeframe | Documentation
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| who is licensed, waivered, and/or under the direction of a LPMH.” | (MHSUDS Information Notice No. 17-040) | 

### Assessment Service Activity

Assessment activities are usually face-to-face or by telephone with or without the client or significant support persons and may be provided in the office or in the community. An assessment may also include gathering information from other professionals. Examples include the following:

- Interviewing the client and/or significant support persons.
- Administering, scoring, and analyzing psychological tests, symptom measures, and outcome measures, etc.
- In some instances, gathering information from other professionals (e.g., teachers, previous providers, etc.) and reviewing/analyzing clinical documents/ other relevant documents may be justified as contributing toward the assessment.
- Observing the client in a setting such as milieu, school, etc. may be indicated for clinical purposes.
- Although an Assessment is provided during the first 60 days and every two (2) years, it may be updated or administered at other times, as clinically appropriate.

### Progress Note Tips:

- The information recorded in an assessment form or report does not need to be repeated within a progress note. However, the progress note should include some information about what transpired.
- Each assessment activity requires a matching corresponding progress note.
- When completing an assessment report, the progress note date should match the assessment report completion date.
- Providers should not estimate the time spent assessing a beneficiary. Time can be assessed piece by piece or totaled and submitted as one claim (MHSUDS Information Notice No. 17-040).
- **Chart review** is reimbursable as part of an assessment service.

### Scope of Practice

See Scope of practice table, [Appendix B](#)
V: NARRATIVE SUMMARY

Action & Outcome

The narrative summary is sometimes referred to as a “clinical formulation” because it involves taking all the disconnected bits of data collected during the assessment process, identifying the items that are most relevant to the Individual’s or family’s stated purpose for seeking help, and weaving them into a coherent summary of the their experiences that includes a clinical hypothesis.

The Narrative Summary is also a process of creating a collaborative dialogue and a shared understanding between the Individual, his or her natural support system, and the provider(s) who will be working with them to support engagement and create positive change. It is the bridge between the assessment process and the creation of the plan. A well-written narrative demonstrates that the service provider has heard the Individual/family and support system and worked with them to weave the pieces of the story together. The narrative will facilitate further shared decision-making to create a plan for achieving their goals.

Assessment and diagnoses are a description of the Individual’s or family’s experience and concerns. The Narrative Summary is a clinical understanding of the experience and concerns. Whereas the assessment data is about what, the Narrative Summary is about how and why. It is not a retelling of the assessment data, but rather an integration that relies on the insight and interpretation of the provider. It is an effort to make sense of the needs and concerns and what motivates the Individual or family.

Why a Narrative Summary?

- The Narrative Summary becomes the basis of a healing partnership that supports the Individual’s resiliency and shows the family respect.
- The formulation process facilitates shared understanding, which supports engagement and strengthens the alliance.
- A shared understanding helps develop a treatment plan that is meaningful for the Individual/family.
- It provides a rationale and framework for meeting the Individual and family where they are and the collaboration ahead.

Standards of Practice

Clinical Practices: Formulating the Narrative Summary takes practice for a provider to navigate skillfully through the formulation process to reach a point of shared understanding. Making use of clinical consultation with peers and supervisors and building on the experience of others will be helpful in developing this important skill.

Because the story told in the narrative summary also includes the Individual or family’s strengths, protective factors, and cultural identity, it can indicate potential methods or interventions that might be used in the process of accomplishing the Individual/family’s goals. Methods that are trauma-informed, as well as strength- and culture-based are not only likely to be more successful, but they are also more likely to be welcomed.
by the Individual and natural support system. A helpful way to crystallize one’s thinking and avoid simply rewriting the assessment is to remember that the narrative is an explanatory document that seeks to answer the following 4 questions:

- How did we get here? (Explain likely reasons for both the concerns and the strengths)
- What is keeping us here? (Maintaining factors)
- Where do we want to go? (Individual/family’s dreams/desires)
- How might we get there? (Possible next steps and interventions)

**Elements of a Narrative Summary**

Thoughtful consideration and inclusion of the elements described below will add richness and meaning to the understanding of the Individual and family’s story. They are listed separately here to provide some information about each one, but they are interrelated and can be incorporated throughout the Narrative. Understanding these elements will help to formulate the clinical hypothesis. The clinical hypothesis must be included in the Narrative Summary in order to distinguish it from the Assessment.

**Strengths:**

When a narrative summary leads with strengths, it presents a hopeful, resiliency/recovery-oriented vision of the Individual and family that will lead to a care plan with the same vision.

- The Narrative Summary should emphasize **functional strengths**—the strengths that the individual and family can use to help them overcome their current concerns and support their success.
- Consider strengths that have been helpful to the Individual or family in the past, which may be able to help them now
- Remember that cultural factors can be great strengths
- Hopes and dreams provide meaning, purpose, and something to aspire to. They can be included with strengths in the Narrative Summary.

**Cultural Factors:**

- Developing a narrative summary requires understanding the cultural background of the client and his or her natural support system. Culture influences our identities and actions, so it is essential to include a discussion of culture into the formulation.
- Consider how cultural factors may impact treatment and help the individual and family toward their success.

**Interfering or Perpetuating Factors:**

- Certain factors in the life of an individual, or the lives of people in his or her natural support system, might be sustaining the problem.
- It is important to consider the factors that are currently maintaining or contributing to the barriers and/or obstacles.

**Stage of change and developmental factors:**

- [Stages of Change (appendix D)](appendixD) and developmental factors help to broaden our understanding of where an Individual or family is in relation to their issues/concerns and where they want to go.
Developmental stages, stages of change, and relational influences may impact an Individual or family in different ways. For example: a child’s individual level of development and the uniqueness of his or her maturation process may be affected by familial relationships, especially caregiver relationships. An adult’s stage of change may be affected by the relationship with his or her spouse or closest friend.

It is important to include the stages of change or developmental factors that are relevant to the Individual and family’s current concerns and aspirations.

Natural Supports/Community Resources:

- Natural supports can include family members, extended family, neighbors, friends, clergy, and traditional healers.
- Community resources can include recreational connections, cultural centers, schools, and other community agencies/supports.
- Natural supports and community resources if under-developed should be focused on as an important aspect of treatment to increase the chances that the Individual and family are successful in sustaining change outside of the system.
- These supports may already be in the Individual and family’s life, or may be something new that would support recovery and success.

Clinical Hypothesis:

- The clinical hypothesis provides a conclusion to the story by tying relevant factors together and explaining how and why the Individual and family’s current needs and concerns came about.
- Logical connections are mapped out between recent and past events. These connections may explain how a particular problem originated.
- The clinical hypothesis should inform the clinical interventions that the provider thinks will best help address the Individual and family’s current concerns and goals.

Processes to Support Engagement

Shared understanding leads to responsive action. Provider’s Narrative Summary integrates the practitioner’s understanding and the family’s perspective. It connects the dots between the presenting concerns, the formulation, and the recommendations.

Sharing the Narrative Summary with the Individual or family should be personable and show that the provider has done the work to understand them more fully. This can raise the confidence of the Individual/family in the process and support the treatment collaboration that follows.

- Writing and sharing the Narrative Summary using language the Individual and family understand will support engagement and help to build the alliance. It is generally best to use common everyday language wherever possible. When clinical terms are used, make sure they are explained and understood.
- Every effort should be made to communicate the Narrative Summary in the Individual/family’s preferred language.
- Individual/family and provider determine who will provide feedback about the Narrative Summary. In some cases, the Individual is a child too young to participate.
meaningfully in the process, and the parent or guardian may provide feedback instead. Adult individuals may choose to involve several members of their family or natural support system in the process. Some individuals may prefer to keep it between themselves and the provider.

- As the individual/family reviews the Narrative Summary with the provider, changes are made as needed. This sharing and collaboration between the individual, family, and provider is ideal for person-centered, family-driven care to take place, because the Narrative Summary is the basis for the next phase of work.
- Educating the Individual/family and other natural supports involved about the use of the Narrative Summary in the treatment planning process is important so that they too can make use of their written story to help drive their own treatment.

### Frequency, Timing and Documentation

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<thead>
<tr>
<th>Activity</th>
<th>Frequency, Timeframe</th>
<th>Documentation</th>
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<tbody>
<tr>
<td>Initial Narrative</td>
<td>The initial Narrative Summary is completed as part of the initial assessment process.</td>
<td>The Narrative Summary will be documented under the Mental Health Conclusions/Narrative Summary section of the county initial and update assessment forms.</td>
</tr>
</tbody>
</table>
| Updated Narrative      | The Narrative Summary may be updated anytime it is clinically appropriate and would benefit the Individual or family to do so, such as when something happens or is learned that changes the understanding. It is best to review the Narrative any time an update or change is made to the Assessment or Treatment Plan. | The writing of the Narrative Summary is not billable as a stand-alone service and must be billed as part of an assessment activity. (MHD Directive No. 2014-01)  
The live presentation of the Narrative Summary to the Individual and/or Family may be billed in conjunction with a plan development service. (MHD Directive No. 2014-01)  
Narrative summaries that only repeat information obtained from the assessment and do not include a Clinical Hypothesis does not meet clinical standards and may be considered out of compliance. (MHD Directive No. 2014-01) |

### Scope of Practice

- The primary provider working with the Individual and/or family should complete the Narrative Summary.
- Paraprofessionals and providers with less clinical training and experience should receive direct supervision when developing the Narrative Summary.
VI: DEVELOPING THE CARE PLAN

Action & Outcome

The entire process of Transformational Care Planning is the driving force behind the delivery of care. The Transformational Care Plan (previously known as a Treatment Plan) is the formal written agreement between the individual and the provider that establishes the focus of the individual’s mental health services.

The Transformational Care Plan (Care Plan, for short) is a dynamic living document that changes over time and continuously guides the everyday work the provider and the individual/family do together and the work the Individual/family will do in the community. A well-developed Care Plan facilitates partnership and is a source of hope and motivation. It also serves as a yardstick with which to measure progress and should be referred to regularly with the Individual and family. The Care Plan is a key element that structures an ongoing partnership based on shared decision-making.

A person-centered, culturally sensitive Care Plan process includes:

- Collaboration and partnership between members of the family or natural support system and service providers in all aspects of the development of the plan
- Articulation of results that are desired by the Individual and significant support people
- Focus on strengths, developmental assets, and protective factors of the Individual and his or her natural support system
- Utilization of the expertise of that family/system about the Individual, and the Individual’s expertise about him or herself
- Incorporation of cultural elements that affect the plan
- Foundation on the values of the Individual in his or her natural environment/system

Standards of Practice

Clinical Practices: Process of Formulating & Writing the Plan

The first challenge in writing the Care Plan involves deciding how to begin. Individuals and their family systems are complex, and they may be confronted by a host of concrete needs that must be addressed, as well as having a variety of hopes, dreams, and strengths.

The first priority in developing a plan is to determine whether there are basic health and safety concerns that need to be addressed. These concerns are critical and primary, and they may involve legal obligations and mandates. The most successful approach is to negotiate and collaborate with the Individual and family members to develop mutual agreement. When basic safety issues are addressed and fundamental needs are met, the Care Plan can begin to focus on achieving the desired results articulated by the Individual and family.

The following are elements of County of Santa Clara’s Specialty Mental Health Care Plan:

Desired Results

- Desired Results express the hopes and dreams of the Individual and family/supports, identifying their vision of life. They embody hope, and an alternative to current circumstances.
Desired results statements are big-picture, longer term, quality of life changes for each Individual and family that reach beyond their mental health symptoms and impairments.

It is important to explore and come to a shared understanding of the Individual’s own statement of desired results and the importance of achieving that vision. In this way the desired result is a shared picture of success.

Some Individuals and family members may have difficulty articulating their desired results. Here are some questions that may help them:

- Is there anything you used to have enjoy doing that you don’t do now, but would like to do again?
- If you woke up tomorrow and everything that you wanted had come into your life, what would be different and how would you know?

If the desired result is meaningful to the Individual and family, then the rest of the Care Plan’s emphasis on progressing toward that will be meaningful, too.

**Desired Transition**

- Describe changes in the individual’s and family’s current needs and circumstances that will need to occur for them to succeed in discharge or transition.
- A desired transition helps the Individual and family see a life beyond their current circumstances and challenges. It also helps foster hope and the development and utilization of community resources and supports.
- The desired result need not be fully achieved for the desired transition to take place.

**Obstacles**

- The obstacles section identifies the factors (functional impairments, behaviors, and/or symptoms) that are interfering with the Individual’s ability to achieve the desired results they want.
  - It’s important to always consider which identified functional impairment is interfering with the life they want because addressing the identified impairments must be the focus of treatment. (Medical Necessity Criteria, CCR, Title 9, 1830.205, 1830.210; MHSUDS Information Notice No. 17-040)
- All impairments, symptoms, and behaviors noted on the plan must be consistent with the qualifying diagnosis (DHCS Annual Review Protocol for SMHS FY 2017-2018)
- Obstacles may also include symptoms of co-occurring diagnoses, environmental situations and circumstances.

**Short-Term Goals**

Whereas the Narrative Summary prioritizes the Individual and family’s needs, Short-Term Goals break down the desired results into manageable functional pieces and help the Individual/family make meaningful life improvements.

- Short-term goals are SMART and must be specific observable and/or specific quantifiable, time-limited, and be consistent with the needs and functional impairments established in medical necessity.
Components of a Short-Term Goal

Using action words, describe the specific changes expected in measurable and behavioral terms, and include target date. The “as evidenced by” prompt can be helpful to ensure measurability.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Individual will</th>
</tr>
</thead>
<tbody>
<tr>
<td>What/Action</td>
<td>Specific behavioral change related to the Individual’s mental health needs and functional impairments as a result of the mental health dx</td>
</tr>
<tr>
<td>Measurable</td>
<td>How often? (e.g. 5 out of 7 days, minimum of 3 times, etc.)</td>
</tr>
<tr>
<td>Duration (Time-Limited)</td>
<td>by (e.g. the end of 3 months)</td>
</tr>
<tr>
<td>As evidenced by?</td>
<td>How will the Individual/family know they are improving in this area? (e.g.: scale, log, self-report, teacher/family observation &amp; report, etc.)</td>
</tr>
</tbody>
</table>

Short-term goals are the outcome of action steps and interventions - they should display a change in functioning as related to the medical necessity established in the assessment.

- Achieving short-term goals is a measure of on-going treatment services and a way to monitor progress, thus should be updated regularly.
  - Goals are milestones & intermediate/smaller steps towards their desired results. The time frame of the short-term goal should allow the Individual or family to experience the success of its accomplishment in a relatively short period of time. 90 days or less is ideal and in-line with national standards.
    - If the goal will likely take longer than 3 months to accomplish, it may be useful to break it down into smaller steps. This allows the Individual and family to experience success that increases their hope, motivation, engagement, and alliance with the provider.
    - The duration of the goal will be determined collaboratively by the individual and the provider. Therefore, a goal may be longer than 90 days, if clinically indicated.
    - To update the goal during the life of the annual plan, complete an interim update.
- Utilizing their strengths and culture to build their life skills and abilities helps make them more achievable and meaningful.
- It is recommended that Short-Term Goals be framed in positive terms (what adaptive behaviors/functioning ability will improve because of the interventions and other action steps) rather than negatively framed (reduction of impairments or symptoms).

Short-Term Goal Tips

- Try to refrain from symptom-focused goals.
- What is going to improve as a result of the things you and the client do in the actions steps?
- The best short-term goals outline a functioning improvement of one of the identified functional impairments.
- Limiting the number of short-term goals is desirable because it makes their achievement more manageable. It is not recommended to have more than two.
Individual/Family/Supporters Strengths (Functional Strengths)

- While the obstacles section notes the factors that get in the way of movement toward the desired result, the strengths section notes the factors that can help the individual/family move toward that.
- Functional strengths are those that the Individual and family/natural supports can utilize to help accomplish the short-term goal.
- The provider should recognize and point out strengths they see that the Individual or family may not be aware of and how they are relevant to the Short-Term goal.

Action Steps by Individual/Family/Supporters

- The purpose of this section is to help the Individual access family, friends, activities, community resources, and other natural supports outside of their mental health treatment to help promote recovery and provide additional support to their goals.
- These connections can augment and enhance their mental health services in several ways, such as support community integration, reduce isolation, expand interests, help overcome stigma, increase motivation, promote friendship and social networking.
- It is likely that over the course of services with the Individual/family that more resources will be identified and they should consistently be incorporated into care.
- Attending appointments and other mental health treatment related actions should only be used if requested by the Individual/family.
- The Individual/family's access and participation with natural supports, meaningful activities, and community resources contributes the most to success, long term community integration, and recovery.

Action Steps by Staff (Interventions)

- Each intervention must include the mode-specific service (treatment category: Case Management, Individual Therapy, Collateral, Rehabilitation, Medication Support Services, etc.), frequency, duration, and be linked to the short-term goal. These elements allow the Individual and the Family who supports them to know what to expect from the services.

<table>
<thead>
<tr>
<th>Who</th>
<th>Which member of the team or support system will provide the service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What</td>
<td>What mode-specific service (Individual therapy or rehab, case management, group therapy or rehab, psychiatric/medication support, etc.) and intervention description (Evidence-Based Practices, techniques, etc.) will be provided.</td>
</tr>
<tr>
<td>When</td>
<td>Frequency: 1x/wk, 2x/month, etc. Duration: 2 months, 3 months, 12 months, etc.</td>
</tr>
<tr>
<td>Why</td>
<td>Identify the purpose/intent/impact of doing the actions. Link the Interventions back to the short term goal/desired outcome - what will the Individual be able to do as a result of the intervention.</td>
</tr>
</tbody>
</table>

- Intervention frequency must be stated specifically (e.g., daily, weekly, etc.), or as a frequency range (e.g., 1-4x’s monthly). As needed, PRN, etc. do not meet the proposed frequency requirement (MHSUDS Information Notice No. 17-040).
• Interventions must address an identified functional impairment that is consistent with the currently established medical necessity criteria.
• Action steps by staff are the detailed interventions agreed upon to help Individuals overcome their obstacles and achieve their short-term life improvement goal.
• Only those specific interventions currently agreed upon and provided should be included. Services/interventions may be added or changed as new needs emerge. To reflect this in the plan, complete an interim update.
• Symptom reduction and management should always serve and support meaningful life functioning improvements and new skills/abilities.

Processes to Support Engagement

Collaboration, partnership, and shared decision making is the cornerstone in supporting engagement and developing the alliance. It is important that the individual/family’s right to be in the driver’s seat is respected and that their voice is reflected in the care plan. The provider’s role is to utilize both the Individual/family’s hopes and dreams and their own professional expertise to create the plan.

To facilitate a person-centered collaboration and a shared vision, there must be agreement on all the plan elements between the provider and the Individual she/he is working with. On the care plan, the collaboration and engagement begins with the desired result. The more important and meaningful the desired result is to the Individual/family, the more engaged and motivated they will be to work towards it. This sets the foundation for developing the short-term goals and the rest of the care plan.

Maintaining a focus on strengths, wanted life improvements, and skill building will further enhance engagement and strengthen the alliance. Active collaboration and shared decision-making can help bring to light positive aspects about someone that had previously been neglected or unknown. This helps support engagement and increases the belief in oneself that they can succeed.

There may be challenges to a collaborative process for all involved. Diligence in finding and acknowledging the Individual/family’s strengths and resources, and exploring what motivates them may help to instill hope. Talking about the collaborative relationship and the services may be helpful and provide an alternative perspective for the Individual and the provider. Examining our own expectations for these Individuals and what their expectations are for us may help enhance the collaborative relationship. Processes of engagement and collaboration take time to develop and will vary from one Individual to another.

Frequency, Timing & Documentation:

<table>
<thead>
<tr>
<th>Components</th>
<th>Frequency, Timeframe, Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Care Plan</td>
<td>An individualized client plan must be completed prior to service delivery for all planned services (MHSUDS Information Notice No. 17-040)</td>
</tr>
<tr>
<td>Provision of services prior to a client plan being in place OR when</td>
<td>The following Specialty Mental Health Services (SMHS) activities are reimbursable prior to a plan being approved: 1. Assessment</td>
</tr>
</tbody>
</table>

SECTION VI: DEVELOPING THE CARE PLAN
### Components | Frequency, Timeframe, Authorization
--- | ---
there is a “gap” between plans | 2. Plan Development  
3. Crisis Intervention  
4. Crisis Stabilization  
5. Medication Support Services  
   a. for assessment, evaluation, or plan development; or if there is an urgent need, which must be documented  
6. Targeted Case Management and Intensive Care Coordination (ICC)  
   a. for assessment, plan development, and referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services  
7. Crisis residential treatment services - less than 72 hours  
(MHSUDS Information Notice No. 17-040)

### Services disallowed if provided without an authorized care plan | An approved client plan must be in place prior to service delivery for the following Specialty Mental Health Services (SMHS):
--- | ---
1. Mental health services (except assessment, client plan development)  
2. Intensive Home Based Services (IHBS)  
3. Specific component of TCM and ICC: Monitoring and follow-up activities to ensure the beneficiary’s client plan is being implemented and that it adequately addresses the beneficiary’s individual needs.  
4. Therapeutic Behavioral Services (TBS)  
5. Day Treatment Intensive  
6. Day rehabilitation  
7. Adult residential treatment services  
8. Crisis residential treatment services - after 72 hours  
9. Medication support (non-emergency)  
10. Psychiatric Health Facility Services  
11. Psychiatric Inpatient Services  
(MHSUDS Information Notice No. 17-040)

### Providing services requiring a plan prior to full plan completion | A provider may prepare a plan within a short period of time in order to quickly begin providing as few as one of the services that require a plan (see above). The plan is a dynamic and living document to which services may be added over time (MHSUDS Information Notice No. 17-040). See “Admit Care Plan” in Timelines component below.
### Components

<table>
<thead>
<tr>
<th><strong>Interim Update</strong></th>
<th><strong>Frequency, Timeframe, Authorization</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The primary purpose of the Interim Update is to amend the Short Term Goals and/or the Action Steps by Staff (Interventions), as they represent changes in the Individual’s recovery process. This does not mean all sections of the existing plan would need to be re-created. The County-developed an Interim Update form or an agency-specified plan update form may be used.</td>
<td></td>
</tr>
<tr>
<td>If a Short Term Goal’s planned completion date passes and the plan authorization period is still in effect, an interim update or a new treatment plan, if appropriate, must be done.</td>
<td></td>
</tr>
<tr>
<td>Strengths and Action steps by Individual/family/supports could be updated if there is a benefit to the Individual and the update supports the current short-term goal.</td>
<td></td>
</tr>
<tr>
<td><strong>Best practice:</strong> Any time an updated assessment and/or CANS assessment (if applicable to your program) is done, the plan should be reviewed and changed, if needed.</td>
<td></td>
</tr>
</tbody>
</table>

| **Renewal** | A new Care Plan should be created when major changes occur such as diagnosis, impairments, and desired result or when the authorization period is about to expire. |
| Each new Care Plan can be authorized for a maximum of one year. A new Care Plan supersedes the previous plan. |

### Timelines

- **Initial**
  - An initial individualized plan must be completed by 60 days after entry into the program.

- **Transfers**
  - Completed by 60 days after entry into the new program

- **Authorization period**
  - Up to 12 months
  - If goal(s) and/or intervention(s) expire or need clinical updates prior to Auth Period end date and services are being provided, an Interim Update or New Care Plan must be completed

- **Interim Updates**
  - The new authorization period for the Interim Update will begin on the date of the LPHA signature for the interim update and end on the End Date of the original authorized plan.

  The authorization period for the regular care plan will be used towards the authorization of the interim update plans. This means that the interim update plan cannot be authorized beyond the “End Date” of the regular treatment plan.

- **Renewal**
  - Completed within the month prior to plan expiration
### Components

<table>
<thead>
<tr>
<th>Components</th>
<th>Frequency, Timeframe, Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crisis Residential</strong></td>
<td>The requirement for Crisis Residential treatment services is included in the California Code of Regulations (CCR), title 22, section 81068.2 Needs and Services Plan (NSP), which states: (b) For each client admitted, the licensee shall ensure that a written Needs and Services Plan (NSP) is started prior to admission, and completed prior to or within 72 hours of admission. Therefore, a treatment plan needs to be in place for those in a Crisis Residential treatment facility within 72 hours of admission.</td>
</tr>
</tbody>
</table>
| **Admit Care Plans (optional)** | This is an optional plan - it is not the equivalent to or to be confused with an Initial Care Plan. Admit Care Plans are only needed when planned services are being provided prior to the completion of the initial assessment and initial treatment plan. In order to provide a planned service, there must be a working diagnosis. Following the QA Workgroup meeting on 10/25/17, CSC QA Department has provided this statement regarding Admit Care Plans: Expectation for the “Admit Care Plan” start date:  
  - “Admit Treatment Plans” will be honored prior to the completion of an assessment or regular treatment plan when the clinician determines that the planned service/s are needed for the wellness of the consumer. The Admit Treatment Plans are to be used during the initial opening of a case and are intended to be for a short period of time, no greater than 60 days. The start date of the authorization period can be the date the consumer was opened to the program with the understanding that the planned services will not be authorized until the LPHA’s signature is obtained. Therefore, any planned services provided prior to the LPHA signature would be disallowed.  
  - Once the regular (initial) treatment plan is completed, it will supersede the Admit Treatment Plan. Make sure you include any services from the admit plan that you are still planning on providing. |

### Signatures

<table>
<thead>
<tr>
<th>Signatures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>The Individual’s signature is required on the Care Plan. If the Individual does not or cannot sign the plan, then a progress note shall document the reason for the missing signature. Ongoing efforts should be made to obtain client’s missing signature unless it is contraindicated. Efforts made and reasons for contraindication should be documented. There is no minimum age for a minor to independently sign their care plan. The minor should understand and agree to the plan.</td>
</tr>
</tbody>
</table>
### Components

<table>
<thead>
<tr>
<th>Frequency, Timeframe, Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family/ supports</strong></td>
</tr>
<tr>
<td>A family or other support person should sign the Care Plan for children/adolescents.</td>
</tr>
<tr>
<td><strong>Staff</strong></td>
</tr>
<tr>
<td>The Care Plan must be authorized by an LPHA whose signature with [County-accepted credential (appendix C)](appendix C), license or registration number (if applicable).</td>
</tr>
<tr>
<td>Remember, the LPHA signature must be completed on or before the start date of any plan. The plan is effective once it has been signed and dated by an LPHA.</td>
</tr>
<tr>
<td>An LPHA must sign the Interim Updated plan as well as the Individual (and the family, if applicable). The LPHA also reviews and authorizes the effective time period of the Plan’s Start &amp; End date.</td>
</tr>
<tr>
<td>If the cost center/program staff who completes the Care Plan is not an LPHA, the Care Plan must also be co-signed by an LPHA. The first date of the authorization period for renewal plans cannot be earlier than the date of the LPHA signature.</td>
</tr>
<tr>
<td><strong>Conservator</strong></td>
</tr>
<tr>
<td>A conservator’s signature is not required on the Care Plan, though, a conservator is often a significant and valuable support person in the Individual’s life. It is best practice to include the conservator in the planning process and their signature on the Care Plan.</td>
</tr>
<tr>
<td><strong>Copies</strong></td>
</tr>
<tr>
<td>Individuals and families must be offered and provided copies of their Care Plans. This is recorded in the client’s plan.</td>
</tr>
<tr>
<td>If the Individual/family does not want a copy, indicate the reason(s) in the progress note and indicate the date of the progress note on the Care Plan.</td>
</tr>
<tr>
<td>Individuals and families must be offered a copy of their Care Plans in their preferred language (other than English). This is recorded in the client’s plan.</td>
</tr>
<tr>
<td>If the individual/family does not want a copy, indicate this on the client’s plan.</td>
</tr>
<tr>
<td><strong>Audit Requirements for Treatment Plans</strong></td>
</tr>
<tr>
<td>During an audit, all treatment plans for the audit period would need to be submitted to Quality Assurance. For example, if the consumer had an Admit Treatment Plan, a regular treatment plan, and any interim treatment plans, all of these documents would need to be submitted with the consumer’s chart.</td>
</tr>
</tbody>
</table>
### Plan Development Service Activity

<table>
<thead>
<tr>
<th><strong>Definition</strong></th>
<th>“Plan Development” means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress. (CCR Title 9 Division 1, 1810.232)</th>
</tr>
</thead>
</table>
| **Activities** | Plan Development activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. Plan Development may also include contact with other professionals.  

Plan Development may be with or without the Individual and include the following:

- Developing the plan
- Approval of the plan
- Updating the plan
- Monitoring Individual’s progress on the plan
- Discharge Summary (should have face-to-face or phone contact) |
| **Progress Notes** | Plan Development progress notes are expected to refer to the Care Plan and the related activity (i.e., development, approval, monitoring, updating, discharge)  

Discharge Summaries may be documented in a form or progress note. If a form is used, it must be referenced in the note. |
| **Discharge Summary** | A discharge summary must include at a minimum the following information:  

1. Initial need for treatment or presenting problem  
2. Summary of treatment goals  
3. Progress made toward treatment goals  
4. Reason(s) for closing the case - clinical or administrative  
5. Post discharge needs/plans (including any referrals made or needed)  
6. Discharge medications  
7. Discharge diagnosis  

**NOTE:** Best practice is to collaboratively develop the discharge summary with the Individual/family. |
| **Chart Review** | **Chart review** is reimbursable as part of a plan development service. |
| **Multiple billing** | Multiple Plan Development service activities for one event are at risk of disallowance, if inappropriately documented. |

### Scope of Practice

See Scope of practice table in **Appendix B**
VII: IMPLEMENTATION AND EVALUATION OF CARE PLAN

Ongoing Review as to Whether Short Term Goals are Being achieved

Action & Outcome

On a regular basis, an objective assessment of progress and/or improvement (“evaluation”) should be completed, as well as an assessment of whether or not services are being delivered in the manner in which they’re intended (“fidelity monitoring”). Providers should have open conversations with Individuals/families at all stages of intervention regarding the process and progress of services and support, so that Individuals/families feel comfortable expressing any concerns. Based on evaluation and Team discussion, intervention goals are modified and/or changes to the services and supports are implemented; all driven by consensus between the individual/family and provider.

In general, implementation and evaluation of the Care Plan includes:

- Development of relationship and therapeutic alliance
- Monitoring progress on goal achievement and life improvements
- Consultations with other providers, supervisors, peer partners, family, other supports
- Clinical Supervision

If progress of Individual/family achieving their goals is not being made as anticipated and/or services and supports are not being delivered and utilized as intended, changes to the goals and/or interventions should be made.

Standards of Practice

Clinical Practices

On-going evaluation of an Individual’s progress and the quality of services provided can be gained from a variety of practices and tools. Many of these practices are routinely done and just require utilizing their evaluative capacity. Additional measurement tools as mentioned below can also be utilized. All evaluation practices help to enhance the services provided and better support Individuals toward wellness and recovery. A literature review demonstrated that frequent and consistent progress monitoring done with clients utilizing a measurement tool improved outcomes (J. Goodman, J. R. McKay, and D. DePhilipps, 2013).

Care Plan

The Care Plan is a useful and meaningful clinical tool, which can serve as a valuable evaluation instrument. Because the Short-Term Goals are of much shorter duration in TCP practice, frequent review of the Care Plan goals and interventions with an Individual/family is necessary. Goals/plan reviews should be brief and a part of regularly scheduled sessions. Making this a routine practice has significant evaluative value and assures that the plan and interventions are on track and supporting goal achievement. This will also assure timeliness of needed adjustments such as updates when Short-Term Goals are achieved or when there is a lack of progress toward goal achievement. It is essential that the services and interventions
provided are effective. In general, assessment and Care Plan monitoring is an on-going process that considers a number of factors including:

- New information that affects or informs any of the Care Plan elements
- Significant life events that affect health, mental health, substance use, employment, relationships, living environment, etc.
- Individual or family shifting and wanting to work on different goals
- Emergence of new strengths or resources
- Emergence of new or different obstacles
- New concerns or needs
- Stage of change
- Impact of services and interventions - are they helping?

**Individual/Family Feedback**

Regular and frequent feedback from the Individual/family regarding their progress and services is a reliable indicator of the alliance and strongly associated with better engagement and outcomes. Some important areas to receive feedback include:

- Alliance and Relationship
  - The practitioner approach is compatible with the Individual’s/family’s preferences, strengths, and needs
  - The Individual/family feels heard, understood, and respected
- Goals/services
  - Goals are important and meaningful for the Individual/family
  - The Individual/family’s stage of change is consistent with the goal and what they are working on
  - Services/interventions are compatible with the Individual/family's preferences, strengths, and needs

**Provider/Team Self-Assessment**

To support quality improvement, practitioners are encouraged to reflect on and evaluate their own practice and role in service delivery and goal achievement. Collaboration with other team members about engagement and how services are provided can add additional perspectives. This practice supports all team members while helping to improve services and enhance the experience of the Individuals/families they are serving. Some factors to reflect on may include:

- Does the Individual/family feel supported, respected, and included?
- Are their values, beliefs, and preferences respected and accounted for in the plan?
- Are their strengths being talked about and utilized to accomplish goals?
- Has the Individual/family shared in the decisions about their plan elements?
- Are they engaged in working towards accomplishing their goals and making progress?

**Assessment Updates**

For Individuals and families that require longer term support, the required assessment update can be a valuable tool to evaluate progress and services. Relevant changes over the course of a year can be small and not always apparent. Reviewing the record for the past 12 months may reveal some significant changes and events for the Individual/family that could go unnoticed otherwise. It allows consideration of the past year as a whole, which can provide a
useful perspective and help to see connections that may not have seemed related during the course of treatment. The update assessment is an opportunity to provide hope and encouragement. It can also illuminate new directions for services and the plan.

Factors to consider in this process include:

- The goals accomplished
- Other accomplishments or improvements
- New or developed abilities and strengths
- Losses and setbacks
- New challenges and obstacles
- Changes in the alliance
- How scores of any assessment/monitoring tools used changed and fluctuated

Outcomes/Evaluation tools

Evaluation and monitoring tools administered at consistent intervals are helpful in evaluating an Individual’s progress in the area the tool being used is designed to measure. The relationship or link to specific Care Plan elements may not always be obvious and may require further consideration.

When Individuals and families see their progress indicated in the measurements being used, it supports their self-efficacy and hope for recovery. Willingness to use measurements to quantify progress, or lack thereof, demonstrates to Individuals/families that their hopes, dreams, and wellness are important.

Factors to consider when using outcome measures to evaluate progress include:

- Understand what the tool is measuring
  - Broad measurements examine overall functioning, distress/symptomatology, strengths, etc.
  - Narrow measurements look at specific functioning, symptoms, behaviors, skills
- Document and/or chart scores so that changes over time are easy to see and readily available
- Measures prescribed by an evidence based practice (EBP) are used in accordance with the EBP

It is important that all tools and scores are reviewed and discussed with Individuals and families. Outcomes & Evaluation tools to monitor an Individual’s progress may include (Program requirements must be applied):

- Child and Adolescent Needs and Strengths (CANS)
- Child Behavior Checklist (CBCL)
- Client Feedback Tool (brief recovery outcome measure)
- Pediatric Symptoms Checklist (PSC-35)
- Milestones of Recovery Scale (MORS)
- Session Rating Scale (SRS)/ Outcome Rating Scale (ORS)
- Strengths and Difficulties Questionnaire (SDQ)
- Treatment Effectiveness Assessment (TEA)

Family members and others in the Individual’s life (e.g. teachers) may be asked to complete standardized questionnaires or participate in other kinds of evaluation activities that help
providers get a clear sense for the helpfulness of the current Care Plan as it is being implemented.

**Progress Notes**

The progress note itself is another opportunity to monitor the progress that an individual/family is making towards achieving their goal(s) and improving functioning. Many services require that a response to the intervention(s) provided is written in the progress notes.

Considering these responses is an opportunity for the provider to reflect on and record how an Individual’s progress toward goal achievement and improved functioning was aided by the intervention in each session. Progress notes can show progress over time or indicate that changes are needed when they show a lack of progress.

Progress notes also require showing a connection to the Care Plan. The practice described above makes sure that is maintained while focus is kept on the quality of services and goal achievement.

When Individuals progress toward or achieve a Short-Term Goal, it is not unusual to see progress and improvement in other areas of their life. Those gains can also be noted progress notes.

**Processes to Support Engagement**

Individual/family engagement is supported by their inclusion of the progress monitoring process and conversations about what it means for them. When people experience success, their hope, motivation, engagement, and alliance with the provider are enhanced.

- The time frames of the short-term goal and interventions should allow the client and family to experience the success of accomplishment in a relatively short period of time.
- Be sure and give feedback on progress and setbacks, and do not become overly attached to an outcome; align with your participant.
- Remain flexible with your client and the family, as they may modify or eliminate goals at any time. We want to support them where they are and shift with them when necessary.
- Listen for ways in which the client and family may want to expand upon a goal to improve wellness or reach their desired results.

Plans are an integral part of a client’s recovery journey. Therefore, updating them and observing the progress someone is making helps to inform our system of care, as well as (and most important) instill a sense of hope in the client and family.
**Frequency, Timing and Documentation**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency, Timeframe</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessments</td>
<td>Initial and update</td>
<td>Providers should document all evaluation and fidelity monitoring activities.</td>
</tr>
<tr>
<td>Transformational Care Plan</td>
<td>Consistent monitoring</td>
<td>Evaluation tools and forms should be used in accordance with their intent, design, and instructions/manuals, etc.</td>
</tr>
<tr>
<td>Services &amp; Progress notes</td>
<td>Every session should check on the relevance &amp; connection to goals and interventions</td>
<td>Note progress toward treatment goal and how an identified functioning impairment is improving. (<a href="#">MHSUDS Information Notice No. 17-040</a>)</td>
</tr>
<tr>
<td>Outcome/evaluation measures/tools</td>
<td>Used frequently and consistently supports improved outcomes</td>
<td>Agency and program policies should be followed when documenting specific measurement tools used in any setting.</td>
</tr>
</tbody>
</table>

**Scope of Practice**

Implementation and evaluation of a care plan may be provided by all qualified practitioners.

Specific Outcomes/Evaluation tools may require additional training to administer and evaluate.

Approval of care plans is limited to LPHA’s. See Scope of Practice table in [Appendix B](#).
VIII: TRANSITION PLANNING

Individuals/Families Have Capacity to Support and Monitor Their Progress

Action & Outcome

Transition planning is an essential practice in promoting hope and a life beyond mental illness. Discussing and agreeing on what completion of services will look like can be very empowering and motivating for Individuals/families. Transition planning supports resiliency and self-efficacy on a path to fewer formal service needs or none at all.

The transition phase draws upon the ongoing, TCP person-centered/ strength-based assessment & wellness planning which takes place throughout the duration of treatment. Careful consideration to the frequency of sessions, redirection of treatment focus towards accessing developed natural supports, utilization of developed skills and internal strengths, and relapse prevention can teach Individuals how to identify, strategize and resolve their own issues and problems. Empowering the Individual/family towards self-efficacy and capability to navigate challenges and progress towards personal goals is an important emphasis in treatment. As identified goals are met, formal services and supports may no longer be necessary.

Standards of Practice

Clinical Practices

Transitions and adapting to changes, even when they are positive changes, are often challenging and stressful. A transition from specialty mental health services to independent living in the community or a lower level of care can be significantly stressful for an Individual/family. On-going collaboration with Individuals/families and planning for these transitions can go a long way in reducing their stress and increasing their likelihood for success. The following practices can help prepare an Individual/family for these transitions:

- Review of remaining needs before a transition plan can begin
- Discussing concerns Individuals/families may have regarding the end or change of formal services and supports
- Identify progress that has been made, and develop a plan to use if/when challenges arise in the future.
- Review existing strengths and assets that can be leveraged for continued success and wellness.
- Help Individuals/families identify strategies and tools to monitor symptoms over time, recognize triggers and early signs of recurrence, access resources and skills that help alleviate symptom distress, and access pathways back to formal services and supports again if needed.
- Work with Individuals/families to acknowledge and access natural community supports for ongoing health and wellness.
Transition Planning at the Start of Treatment

Transition planning is essentially an expectation and plan for recovery (“A life worth living beyond the mental health system which brings meaning, purpose, and a positive sense of self-identity.” [Rapp & Goscha, 2009]).

It is essential to consider and plan for the transition early in an Individual's/family's engagement in a treatment program. Generally, there are beginning, middle, and end phases or stages in mental health treatment. Some programs may have defined time limits while others may use assessment and outcome data to determine readiness for transition. Conditions exist in all programs under which services will be offered, continued, and terminated. An explanation of these conditions early in the process helps Individuals/families have a clearer understanding about what they may expect from the program. It also helps to define roles of the providers and establish healthy boundaries. Transition planning should continue throughout treatment/services to help Individuals/families see a life beyond mental illness and prepare for success.

Care Plan

The Care Plan elements can be useful tools to help shape the on-going Transition Plan development during the course of services:

- The Desired Transition identifies the goals for transition
- The accomplishment of Short-Term Goals can identify and track new skills and functioning improvements
- The Strengths section helps to remind the Individual/family about their internal and external assets and supports that helped them make progress.
- The Action Steps by Individual/Family/Supports identify the new and/or developed community supports and resources that have been gained
- The Action Steps by Staff can identify some of the tools learned that facilitated goal accomplishments and functional improvements

Case Conferences

Case conferences are an opportunity for Individuals/families with a treatment team and additional supports/providers to discuss and identify accomplishments and progress toward transition along the way.

The Transition Plan

It best serves the Individual/family to have a written plan they can refer to. This can be a helpful tool for them when challenges arise. Helpful items to consider on a Transition Plan may include:

- Progress made: Increase in family and/or individual functioning, awareness of personal accomplishments, and ability to identify most-utilized personal strengths
- Prevention Planning (“What are the things I can do on a regular basis to stay well?”)
- Community Supports (“Who can I turn to for support or assistance?”)
- Social Groups
- Recreational centers/groups
- Organizations, e.g., churches/spiritual, cultural, YMCA, etc.
- Health care resources, e.g., medical dental, mental health, etc.
• “Trigger” Plan/Coping skills (“How do I know if I’m starting to slip and what I will do to avoid relapse?”)
• Natural Supports (Who am I connected to? Who are my teachers? Who are my spiritual guides?, etc.)
• Individual/Family/Supports Strengths
• Steps to access formal services (if needed)
• Roles and responsibilities of Individual/family/supports
• Personal vision/dream for their life in the community

The commonly utilized Discharge Summary could include information such as described above and provided to the Individual/family.

**Wellness Action and Recovery Plan (WRAP)**

WRAP is an evidenced based practice and the plans have essentially all of the items noted above. They are done with the Individual/family and a certified WRAP facilitator. Some rehab counselors and many peer support workers are certified WRAP facilitators. There are WRAP groups that can also assist with developing a WRAP plan.

Other WRAP resources include Consumer Affairs (408) 792-3935, Family Affairs (408) 792-2166, and Ethnic and Cultural Communities Advisory Committee (ECCAC) (408) 792-3912. ECCAC provides peer and WRAP support in the community.

Referral to a WRAP resource can be invaluable support to the Individual/family and their services, Care Plan, and provider.

**Transition to a New Program**

Various types of transitions to other programs sometimes occur. Transitions to different programs may include a lower level of care with reduced services or a program that is a better match for the Individual/family’s preferences or needs. Transitions to a different program should also be planned for and can include the following:

• Discussion with Individual/family to assess possible challenges
• Review of strategies, skills, and supports
• Arrange visit to the new program location with current provider to meet the new provider(s) and tour the facility (“warm hand-off”)
• Coordination with the new provider to assure understanding of strengths, needs, supports, and goals (“warm hand-off”)
• Provide copies of Care Plan, Narrative Summary & Assessment info to the new provider
• Use of additional supports, such as family, peers, parent mentor, etc. wherever possible
• Provide Individual/family with a written transition or WRAP plan
• Overlap of services with the new provider of at least 30 days (CM services may be provided and billed during the overlap of 30 days)
• Ensure the Individual/family has been prescribed medications with refills to cover up through their initial psychiatric appointment with their new service provider
• Do not close the case until the other agency has confirmed the initial psychiatry appointment has been completed
Providers receiving an Individual/family from another program can help facilitate the transition plan. Helpful things to consider may include:

- The Individual’s/family’s loss of the relationship, environment, etc.
- Accommodating the adaptation and adjustment to a new program and provider
- Co-coordinating the receipt of the Care Plan, Narrative, assessment, etc. from the previous provider (“warm hand-off”)
- Overlap of services with the previous provider of at least 30 days
- Inform the previous provider as to when the Individual is opened and has seen the new psychiatrist for medication evaluation and support.
- Discussing with the Individual/family what helped in the previous program, the accomplishments and strengths gained, and what they would like most from their new program
- Review documentation from the previous provider with the Individual/family and update if needed

For additional information on transfers between agencies, please see P&P Section 412-309 (“Client Transfer Between Specialty Mental Health Service Providers”).

Processes to Support Engagement

- Individuals/families will be more engaged in transition planning when they are active participants in its development
- Reviewing treatment successes and progress evaluations like those discussed in the previous chapter can enhance engagement in the transition process by building hope and confidence
- Sensitivity to feelings about the transition and sense of loss Individuals/families may experience can help support engagement and successful transition
- Reviewing the completed Transition Plan or WRAP plan with the Individual/family

Frequency, Timing and Documentation

There is currently no State requirement for a Transition Plan, however, continual discussion of transition and discharge is in-line with recovery-centered care. As discussed in “The Transition Plan” above, writing up a transition or discharge plan is best practice and recommended.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency, Timeframe, Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and Narrative Summary update</td>
<td>When Individuals/families transition from one program to another, the assessment report, including the Narrative Summary section, should be reviewed with the Individual/family and updated if needed.</td>
</tr>
<tr>
<td>Assessment coordination</td>
<td>The new provider has the following options with regards to the existing assessment report:</td>
</tr>
<tr>
<td></td>
<td>1. Complete a new assessment within 60 calendar days, OR</td>
</tr>
</tbody>
</table>
### Activity | Frequency, Timeframe, Documentation
--- | ---
| 2. Accept the prior assessment if the information is current and was completed within the past 2 years. This assessment must be updated within 2 years of the LPHA signature, OR
3. Accept the prior assessment and update if there is additional information, missing information, corrections needed, etc. using a progress note or an update assessment form. | |
| Care Plan review and update | The transitioning provider should provide the most recent Care Plan to the new provider
When the Individual/family begins services in a new or different program and cost center, a new initial Care Plan must be created and signed by an LPHA within 60 days of the Individual/family’s start date.
The new provider and Individual/family should collaborate to decide what elements to carry over from the previous plan. |
| Discharge Plan | Reviewing a discharge summary with a beneficiary for therapeutic purposes is a reimbursable service as long as it is clearly documented. |

**Scope of Practice**

All providers may participate in the on-going Transition Planning process.

The primary provider should be the point person for Transition Planning and collaborate with the Individual/family in creating the Transition Plan or referral for Wellness Recovery Action Plan (WRAP).
IX: MENTAL HEALTH SERVICES

Action and Outcome

Mental health services refer primarily to therapeutic interventions designed to support an Individual’s/family’s recovery goals and functioning improvements in important life domains including social supports, community connections, purpose and meaningful roles, physical and emotional health, and living environment. The interventions are consistent with the goals of learning, development, independent Living and enhanced self-sufficiency.

From the Title 9 definition:

“Mental Health Services” means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency.

Mental Health Service activities include:

- Assessment (refer to Section IV: Assessment, Service Activity, & Documentation)
- Plan Development (refer to Section VI: Plan Development, Service Activity, & Documentation)
- Therapy
- Rehabilitation
- Collateral
- Therapeutic Behavioral Services (TBS)

Standards of Practice

Therapy

Definition:

“Therapy” means a service activity, which is a therapeutic intervention that focuses primarily on symptoms reduction as a means to improve functional impairments. Therapy may be delivered to an Individual or a group of beneficiaries and may include family therapy at which the beneficiary is present. (CCR Title 9 Division 1, 1810.250)

Activities:

Therapy can be face-to-face, or over the telephone, with the Individual or family, and may be provided in the office or in the community. The only exception would be a pre-approved electronic communication for the hearing impaired. Therapy can only be provided by an LPHA or a registered intern/trainee supervised by an LPHA (see scope of practice).

Reimbursable therapy services include:

- Individual Therapy
- Group Therapy (for two or more Individuals)
- Family Therapy at which the Individual is present
- Chart review is reimbursable as part of a therapy service
QA Tips:

- For documentation of a therapy note, the interventions provided must focus on the identified impairment improvement outlined in the plan.
- Individual/family’s response must be included and there must be alignment with the service provided and the Individual’s mental health condition.

Rehabilitation

Definition:

“Rehabilitation” means a service activity which includes, but is not limited to improving, maintaining, or restoring a beneficiary’s or group of beneficiaries’ functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education. (CCR Title 9 Division 1, 1810.243)

Activities

Rehabilitation activities are usually face-to-face or by telephone with the Individual and may be provided in the office or in the community. Rehabilitation can be done as:

- Individual Rehabilitation
- Group Rehabilitation (for two or more Individuals)
- Education, training, and counseling to enhance or build skills (strengths) in the following functional domains:
  - **Health** - strategies for identifying and making healthy choices, which may include engaging with a primary care physician, managing a medical condition, grooming and personal hygiene skills, sleep hygiene, medication education according to one’s scope of practice, meal preparation skills
  - **Daily Activities** - money management, leisure skills, organizing, using public transportation, meaningful roles/activities
  - **Social Relationships** - social skills, communication skills, building meaningful relationships, developing and maintaining a support system
  - **Living Arrangement** - skills to acquire and promote a safe and secure living environment, adapting to new or changing living environments
- **Chart review** is reimbursable as part of a rehabilitation service.

Group Services

- There are two categories of group provided in outpatient services: Therapy and Rehabilitation.
  - Please be clear as to which is being provided, and ensure the leaders providing it are within their scope of practice.
- When providing Group services (i.e., two or more clients), the progress note must include the following items, otherwise it is at risk of disallowance:
  - Type or name of group
  - Total group time, which is the time participating in group
  - Documentation time
  - Travel time, if applicable
  - Number of clients
o Number of providers and their names (if there is more than one clinician) with appropriate credentials
o The specific involvement and time of involvement for each provider in the context of the beneficiary’s mental health needs.

NOTE: For group calculation and sample calculation statement, see Section XIII (Progress Notes - group calculation)

Therapy vs. Rehabilitation

Therapy focuses on therapeutic processes, symptoms, behaviors, emotional experiences, etc. as a means to improve functioning and well-being in major life domains. Therapy services may only be provided by a licensed or licensed-waivered staff. Rehabilitation focuses on supporting skill development to improve functioning in major life domains such as housing, social support, meaningful activities, and health.

Collateral

Definition:

“Collateral” means a service activity to a significant support person in a beneficiary’s life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary’s client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity (CCR Title 9 Division 1, 1810.206).

“Significant support persons” may include parents, siblings, other family members, close friends, teachers, peers, and religious/spiritual leaders. Someone who the Individual feels supported by and agrees to include in their Care Plan can play an integral role supporting goal achievement, recovery, and overall treatment success.

Activities:

Collateral activities are usually face-to-face or by phone with the significant support person, and may be provided in the office or in the community. The Individual may or may not be present.

- Educating or consulting with the support person about the Individual’s mental health condition.
- Training (teaching new skills and behaviors, coaching, etc. to support functioning improvement) or assisting the support person to better support and work with the Individual in their recovery and achievement of their care plan goals.
- Family Counseling: Individual may or may not be present at family counseling sessions
- Chart review is reimbursable as part of a collateral service.

Progress Notes:

- Must include the staff intervention (e.g., education, training, etc.)
The role of the significant support person (e.g., parent, teacher, guardian, close friend, peer, family member, etc.)

How the service supports the Individual’s recovery and care plan goals
- It should document changes that occurred as a result of educating or training the significant support person (e.g. how parents learned and demonstrated new ways of understanding and working with their child’s symptoms & behaviors, how they helped their child’s functioning improve, etc.)

Progress notes for family counseling sessions must clearly document how the purpose of the session was to meet “the needs of the beneficiary in terms of achieving the goals of the beneficiary’s client plan.” (Cal. Code Regs., tit 9, § 1810.206)

Documentation should substantiate that the support person is significant in the Individual’s life.

If billing consultation with a significant support person as a collateral service, documentation must include how the clinician educated or trained the significant support person to better understand or support the Individual. Exchange of information with a significant support person without having an education or training component would qualify solely as a case management service.

Collateral groups (e.g.: parenting groups) are billable with or without the Individual.

**Therapeutic Behavioral Services**

**Definition:**

Therapeutic Behavioral Service (TBS) are supplemental specialty mental health services under the EPSDT benefit. TBS is an intensive, individualized, one to one, short-term, outpatient treatment intervention for clients up to age 21 with serious emotional disturbances (SED) who are experiencing a stressful transition or life crisis and need additional short-term specific support services to accomplish outcomes specified in the written treatment plan. (EPSDT Chart Documentation Manual, September 2007, Pg. 30)

**Activities:**

TBS activities are usually face-to-face with the Individual and can be provided in most settings. TBS-related activities can also be provided to significant support persons in collaboration with other professionals. TBS services should be consistent with and support the Individual’s recovery goal in their out-patient program.

- One-to-one therapeutic contacts typically models/teaches, trains, or supports appropriate behavioral changes
- TBS activities may also include assessment, collateral, and plan development, which are coded as TBS
- TBS is provided only by qualified providers

For additional information, reference the CA DHCS TBS Documentation Manual:

- [http://www.dhcs.ca.gov/services/MH/Pages/TBSManualsE-Newsletters.aspx](http://www.dhcs.ca.gov/services/MH/Pages/TBSManualsE-Newsletters.aspx)
Process to Support Engagement

The following factors should be included in the delivery of each Mental Health Service to support engagement:

- A shared understanding of the service and the desired outcome
- Sensitivity, inclusion, and respect for the Individual/family’s culture and preferences
- The Individual/family’s experience and evaluation of all services
- Each service supports the Individual/family’s recovery and goals
- Reflection by the provider after each service to look for ways to make improvements

Frequency, Timing, Documentation

Frequency and timing of all Mental Health Services should follow the agreed upon schedule in the Care Plan as much as possible.

Scope of Practice

All providers should only provide services within their scope of practice. Please see Scope of Practice table in Appendix B.
X: ADDITIONAL REIMBURSABLE SERVICES

Further Support for Recovery and Quality of Care

Action and Outcome

These service activities provide additional support and modalities for providers to use to support an Individual’s/family’s recovery goals and functioning improvements in important life domains including social supports, community connections, purpose and meaningful roles, physical and emotional health, and living environment.

The following services are included in this section:

- Case Management
- Crisis Intervention
- Medication Support Services
- Day Rehabilitation
- Day Treatment Intensive
- Adult Residential Treatment
- Crisis Residential Treatment

Standards of Practice

Clinical Practices:

Case Management

Definition:

“Targeted Case Management” means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activity may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development. (CCR Title 9 Division 1, 1810.249)

Case Management (CM) includes a broad array of services designed to assist and support Individuals/families in their recovery.

- Linkage - Assist Individuals to access needed services such as psychiatric, medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
- Placement - Assist Individuals to obtain and maintain adequate and appropriate living arrangements.
- Consultation - Exchange of information with others in support of Individual’s services.

Activities:

CM activities are usually face-to-face or by telephone with the Individual or significant support persons and may be provided in the office or in the community. CM may also include
contact with other professionals such as social workers, probation officers, teachers, doctors, etc.

- Communicating, consulting, coordinating and corresponding with the Individual and/or others to establish the need for services and a plan for accessing the services.
- Case conferences/MDT case meetings
- Establishing and making referrals
- Linking to appropriate resources and/or services (i.e., community mentor programs, support groups, recreational or other meaningful activities, etc.)
- Monitoring the client’s access to services
- Monitoring the client’s progress once access has been established
- Locating and securing an appropriate living arrangement, including linking to resources: e.g., Board and Care, Section 8 Housing, independent housing, etc.
- Arranging and participating in visits to potential housing options
- Participating with and supporting an Individual in negotiating their living arrangement contracts.

Before providing a case management service consider the following:

- What can the Individual/family do themselves or with natural/community support to access a resource, etc.
- Does the Individual/family really need this assistance from a specialty mental health provider?
- If assistance is required, is this an activity that the Individual/family would like to be able to do on their own in the future? (Possible desired results or even a new goal?)

Chart review is reimbursable as part of a case management service.

**QA Tips:**

- A CM progress note includes the focus of the assistance/intervention provided to the client (e.g., accessing medical services or community activities)
- Describe how the Individual’s mental health condition interferes with their ability to accomplish the activity on their own.
- Describe how the service supports the Individual’s functioning improvement and care plan goals.
- Beginning notes with Linkage, Placement, or Consultation (depending on the type of CM provided) can make them more clear
- For case conferences/MDT case meetings, Individuals claiming for their participation must describe their role and involvement in the service. The supporting documentation must show how the information discussed will impact the client plan.

**Crisis Intervention**

**Definition:**

“Crisis Intervention” means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Crisis Intervention is distinguished from Crisis Stabilization by being delivered by providers who do not
meet the Crisis Stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348. (CCR Title 9 Division 1, 1810.209)

**NOTE:** Crisis Intervention (CI) is an immediate emergency response that is intended to help the Individual cope with a mental health crisis (e.g., potential danger to self or others, potential life altering event, severe reaction that is above the client’s normal baseline, etc.)

**Activities:**

CI activities are usually face-to-face or by telephone with the Individual and may be provided in the office or in the community.

- Assessment of the Individual’s mental status, acuity of symptoms and current need
- Therapeutic services for the Individual
- Coordination of community resources to stabilize the individual in crisis. (e.g., contact police, coordinating with EPS and transportation via ambulance, collaboration with significant support system for safety planning)
- **Chart review** is reimbursable as part of a crisis intervention service.

**QA Tips:**

- CI progress notes contain a clear description of the “crisis,” in order to distinguish the situation from a more routine event, and the interventions used to help stabilize the Individual.
- Medical emergencies may not be billed as crisis intervention
- A well written crisis intervention note also describes the final disposition and plan, (e.g., 5150, safety plan, mobile crisis team, police response, etc.)
- All services provided during the crisis (i.e., Assessment, Collateral, Individual/Family Therapy, Case Management) shall be billed as Crisis Intervention.

**NOTE:** The maximum amount claimable to Medi-Cal for CI in a 24 hour period is 8 hours (480 minutes) per Individual.

**Medication Support Services**

**Definition:**

“Medication Support Services” (MSS) means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to development related to the delivery of the service and/or assessment of the beneficiary. (CCR Title 9 Division 1, 1810.225)

**Activities:**

MSS activities are usually face-to-face or by telephone with the Individual or significant support persons and may be provided in the office or in the community. MSS may also include contact with other professionals.
• Evaluation of the need for psychiatric medication
• Evaluation of clinical effectiveness and side effects of psychiatric medication
• Medication education, including discussing risks, benefits and alternatives with the individual or support persons
• Ongoing monitoring of the Individual’s progress in relation to the psychiatric medication
• Prescribing, dispensing and administering of psychiatric medications

NOTE: The maximum amount claimable to Medi-Cal for medication support services in a 24-hour period is 4 hours (240 minutes) per client. The following services and descriptions pertain to medical staff:

MD only

• Psychiatric Evaluation MD
• Medication Management
  o Face-to-face visits
• Medication Refill Non Face to Face

Non-MD Medical Staff (PMHNP, RN, LVN, PT, and Pharmacist)

• Medication Support Non-MD
  o Administering of medication per MD orders
  o Evaluation of clinical effectiveness and side effects of psychiatric medication
  o Ongoing monitoring of the client’s progress in relation to the psychiatric medication
  o Medication education, including discussing risks, benefits and alternatives with the client or support persons
  o Psychiatric-mental health nurse practitioners (PMHNP) may prescribe medication under an MD’s supervision
  o Psychiatrist and all Medical Staff Non-MDs (see above) can also provide
    ▪ Medication Injection
    ▪ Prep report other Physicians/Agency (Preparation of report for other physicians/agencies)
    ▪ Review Hospital Records/Reports/Labs (Review of hospital records, reports and labs)

• Aside from MSS, all psychiatrists and most non-medical staff may also provide Plan Development, Case Management or Crisis Intervention as needed.
• For the current County of Santa Clara Behavioral Health Department Medication Practice Guidelines click here.

Med Management vs. Consultation

Collaboration with psychiatrists will help clarify the individual’s mental health condition and make sure that the clinician, psychiatrist, and team are aligned.

• If a case manager consults with a psychiatrist about an Individual who has new stressors in their life and the psychiatrist gives clinical advice, both the psychiatrist and the case manager should bill Case Management
• A case manager consults with a psychiatrist about their Individual who is having many psychosocial problems and is also out of medication. The psychiatrist calls in bridge medication to the pharmacy. The psychiatrist should bill Medication Refill Non Face-to-Face. The case manager should bill Case Management.
• If two psychiatrists are consulting about a case, they should both bill Case Management (consultation).

Day Rehabilitation
Definition:

“Day Rehabilitation” (DR) means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least 3 hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. (CCR Title 9 Division 1, 1810.212)

NOTE: Contact Quality Assurance for more information.

Progress Notes:

• Weekly Summaries
  o DR services require weekly summaries that are reviewed and signed by a Qualified Mental Health Professional (QMHP). A good weekly summary will include Individual’s attendance, participation, presenting problem, interventions, and any skill developments learned.
• Other Requirements
  o Daily attendance and individual group logs
  o Weekly Calendar
  o Staff scope of responsibility schedule

Concurrent MH Services

• Concurrent mental health services are the services that are provided by non DR staff on the same day as DR services. All concurrent mental health services require payment authorizations and they must be received by the Quality Assurance program no more than 2 weeks before the proposed start date. Quality Assurance will accept authorization up to 2 weeks after the proposed start date.
• Authorization received more than 2 weeks after the proposed start date will result in unapproved days.

Miscellaneous:

• Billing
  o For absences, verified program attendance, minimum program hours, and program descriptions (including staff ratios) contact QA staff.
  o Medication Support Services, Collateral, Assessment, and Plan Development are billed separately from DR.
For more detailed information about Day Rehabilitation requirements see MHSUDS Information Notice No. 17-040, Page 21, Section K

Day Treatment Intensive

Definition:

“Day Treatment Intensive” (DTI) means a structured, multidisciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least 3 hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. (CCR Title 9 Division 1, 1810.213)

Progress Notes:

- Daily
  - DTI services require daily progress notes.
- Weekly Summaries
  - DTI services require weekly summaries that are reviewed & signed by an LPHA.

Concurrent MH Services

- Concurrent mental health services are the services that are provided on the same day as DTI services. All concurrent mental health services require payment authorizations and they must be received by the Quality Assurance program no more than 2 weeks before the proposed start date. Quality Assurance will accept authorization up to 2 weeks after the proposed start date. Authorization received more than 2 weeks after the proposed start date will result in unapproved days.

Miscellaneous:

Billing

- For absences, verified program attendance, minimum program hours, and program descriptions (including staff ratios) contact QA staff.
- Medication Support Services, Collateral, Assessment, and Plan Development are billed separately from DTI.

For more detailed information about Day Treatment Intensive requirements see MHSUDS Information Notice No. 17-040, Page 21, Section K

Adult Residential Treatment

Definition:

“Adult Residential Treatment Service” (AR) means rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support.
systems. The service is available 24 hours a day, 7 days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral. (CCR Title 9 Division 1, 1810.203)

**Miscellaneous:** AR is also known as Transitional Residential or Transitional Housing.

**Progress Notes:**

- AR services require weekly summaries that are reviewed and signed by a Qualified Mental Health Practitioner (QMHP)
- Daily attendance logs are required

**Billing:**

- Services shall not be billable unless there is face-to-face contact on the day of service and the client has been admitted to the program. AR may not be billed for days the client is not present.
- Medication Support Services are billed separately from AR.
- Case management services are billed separately from AR.

**Crisis Residential**

**Definition:**

“Crisis Residential Treatment Service” (CR) means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, 7 days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention. (CCR Title 9 Division 1, 1810.208)

**Activities:**

Service activities may include assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

**Progress Notes:**

- CR services require daily progress notes.

**Miscellaneous:**

- Assessment
  - Individuals admitted to CR must receive a mental health and medical assessment, including a screening for medical complications that may contribute to his/her disability, within 3 days prior to or after admission
- Billing
o Services shall not be billable unless there is face-to-face contact on the day of service and the Individual has been admitted to the program. CR may not be billed for days the Individual is not present

Processes to Support Engagement

The following factors should be included in the delivery of each service to support engagement:

• A shared understanding of the service and the desired outcome
• Sensitivity, inclusion, and respect for the Individual/family’s culture and preferences
• The Individual/family’s experience and evaluation of all services
• Each service supports the Individual/family’s recovery and goals
• Reflection by the provider after each service to look for ways to make improvements

Frequency, Timing, Documentation

Frequency and timing of all Additional Services should follow the agreed upon schedule in the Care Plan as much as possible.

Scope of Practice

All providers should only provide services within their scope of practice. Please see Scope of Practice table in Appendix B.
XI: NON-REIMBURSABLE SERVICES, ACTIVITIES & LOCK-OUTS

Action and Outcome

Some services are not reimbursable by Medi-Cal, but may be provided to further support the recovery for the Individuals or Children/Families we serve.

Standards of Practice

Clinical Practices: The following services & activities are examples of non-reimbursable services we can consider to further support the life improvement goals of the people in recovery we are serving.

Non-Reimbursable Services & Activities

- Academic/educational services
- Chart audits/Internal auditing (NOTE: this is different from Chart or Record Review for clinical purposes)
- Clerical tasks (e.g.: faxing, copying, mailing, scheduling/re-scheduling appointments, data entry, etc.)
- Clinical supervision
- Cloning
- Completing mandatory reports and associated phone calls: CPS, APS, Tarasoff, etc.
- Completing Social Security reports/forms when there is no face-to-face contact
- Email except for therapeutic communication with the deaf and hard-of-hearing
- Leaving or listening to phone messages
- Missed appointments (no show’s & cancelations should still be recorded as an activity)
- Personal care services (e.g.: grooming, personal hygiene, assisting with medication, meal preparation, etc.)
- Preparation for a service activity such as session planning, collecting materials for a group, etc.
- Recreation (e.g.: playing basketball, going for walks, etc.)
- Services after the death of an Individual
- Socialization if it consists of generalized group activities which do not provide regular individualized feedback to the specific target behaviors of the clients involved
- Staff development (e.g.: trainings, conferences, workshops, reading literature, etc.)
- Translation/Interpretation (see MHD Directive 2011-03)
- Transportation
- Travel time with no face-to-face contact
- Vocational services which have as a purpose actual work or work training

Additional: also see “Services Disallowed if Provided Without an Authorized Care Plan” in Section VI: Developing the Care Plan

Lockouts

Definition:

Services may not be reimbursable by Medi-Cal, with few exceptions, when an Individual is placed in or receiving services from certain settings as indicated
below. A clinician may provide the service (e.g., case management for a client residing in an IMD), but it would not be reimbursable. This should not dissuade outpatient staff from providing services during these situations, as consistent contact is key to both engagement and supporting an Individual or Child’s recovery.

Jail, Juvenile Hall (not adjudicated), IMD
- No service activities are reimbursable except for the day of admission and discharge

Psychiatric Inpatient, Psychiatric Nursing Facility
- No service activities are reimbursable except for the day of admission and discharge
- Exception: Case Management for placement related services 30 days prior to discharge

Adult Residential Treatment, Youth Residential Treatment, Crisis Residential Treatment
- Medication Support Services and Case Management are reimbursable
- No other service activities are reimbursable except for the day of admission and discharge

Crisis Stabilization (EPS, etc.)
- Case management is reimbursable
- No other service activities are reimbursable except for the day of admission and discharge

Day Rehabilitation/Day Treatment Intensive
- Case Management and Medication Support Services are allowed on the same day an Individual is in Day Rehabilitation or Day Treatment Intensive.
- Mental Health Services are not reimbursable on the same day an Individual is in Day Rehabilitation or Day Treatment Intensive without a concurrent authorization from Quality Assurance.

Processes to Support Engagement
The following factors should be included in the delivery of each service to support engagement:

- A shared understanding of the service and the desired outcome
- Sensitivity, inclusion, and respect for the Individual/family’s culture and preferences
- The Individual/family’s experience and evaluation of all services
- Each service supports the Individual/family’s recovery and goals
- Reflection by the provider after each service to look for ways to make improvements
- If any service does not support improved and independent community functioning we should explore why we are providing it.
- While we cannot bill for participating in a recreational activity or vocational services, we should consider providing case management for assisting an Individual with accessing resources or rehabilitation to develop skills towards these activities that their mental health condition may have impaired.
XII: INTEGRATED CORE PRACTICE MODEL SERVICES

Action and Outcome

As a result of the Settlement Agreement in *Katie A. v. Bonta*, the State of California has agreed to take a series of actions that are intended to transform the way California children/youth who are in foster care, or who are at imminent risk of foster care placement, receive access to mental health services, including assessment and individualized treatment.

Children and youth meeting criteria for Katie A. services are understood to have more intensive needs to receive medically necessary mental health services in their own home, a family setting or the most homelike setting appropriate to their needs, in order to facilitate reunification and to meet their needs for safety, permanence and well-being.

The Integrated Core Practice Model (ICPM)

The Integrated Core Practice Model (ICPM) is an intensive service model that requires integration, collaboration, and coordination among mental health services, child welfare (DFCS), families, care providers, and any other natural/community supports available to help the child and family achieve a healthy and enriching development and life trajectory.

Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care

Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care are mental health services added to create a more coherent and all-inclusive approach to the provision of care.

Standards of Practice

Clinical Practices:

Intensive Care Coordination (ICC)

ICC is similar to the activities routinely provided as Case Management (CM). ICC services must be delivered using a CFT to develop and guide the planning and service delivery process.

- A defining feature of ICC activities is that they are to be coordinated with and agreed upon by the CFT.
- Assessment and treatment planning activities can be recorded as ICC when done in the context of a CFT collaboration.
- A mental health provider on the CFT will serve as the ICC coordinator for all ICC service activities.

Intensive Home Based Services (IHBS)

IHBS are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of the child/youth and his/her significant support persons and to help the child/youth develop skills and achieve the goals and objectives of the plan. IHBS are not traditional therapeutic services. IHBS Services include:
• Development of functional skills to improve self-care, self-regulation, or other functional improvements
• Development of skills or replacement behaviors that allow the child/youth to fully participate their family, caregivers, supports, peers, and community
• Improvement of self-management of symptoms
• Education of the child/youth and/or their family or caregiver(s) about, and how to support their goals
• Support of the development, maintenance and use of social networks including the use of natural and community resources
• Support to address behaviors that interfere with a child/youth’s success in achieving educational objectives

Therapeutic Foster Care (TFC)
TFC is a short-term, trauma-informed, individualized, highly coordinated SMHS provided by a specially trained and intensely supported TFC parent. TFC is available as an EPSDT benefit to children and youth under age 21, who are Medi-Cal eligible and meet medical necessity criteria.

• TFC is intended for children and youth who have complex emotional and behavioral needs, and require intensive and frequent mental health support in a family environment.
• There must be a CFT in place to guide and plan TFC service provision.
• It is not necessary for a child or youth to have an open child welfare case, or to be involved in the juvenile justice system, to be considered for TFC.
• Children and youth receiving TFC also must receive ICC and other medically necessary SMHS, as set forth in the client plan.

NOTE:
Per Information Notice 17-055 (10/16/2017) Removal of the Lockout for Intensive Care Coordination and Intensive Care Coordination and Intensive Home Based Services for Children and Youth in Group Homes or Short-Term Residential Therapeutic Programs (STRTP):

• Effective July 1, 2017, ICC may be provided to Medi-Cal beneficiaries under the age of 21 who are placed in group homes or STRTPs, if medically necessary, with no limitation on the number of days that ICC may be provided or reimbursed.
• Effective July 1, 2017, IHBS may be provided to Medi-Cal beneficiaries under the age of 21 who are placed in group homes or STRTPs, if medically necessary.

Processes to Support Engagement
Engagement of the child/youth and their family is foundational to building trust and mutually beneficial relationships between the family and service providers. Engagement is a process that must be nurtured and developed throughout service delivery and is critical in allowing CFT members to work to reach agreement about services, safety, well-being (e.g., meeting critical developmental, health, education, and mental health needs), and permanency.
Frequency, Timing, Documentation

Frequency and timing of all Mental Health Services should follow the agreed upon schedule in the TCP Care Plan as much as possible.

MEDI-CAL MANUAL For Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries

Pathways to Mental Health Services - Integrated Core Practice Model (ICPM) Guide

If you have any questions regarding the Medi-Cal Manual, please email DHCS at KatieA@dhcs.ca.gov

If you have any questions regarding the CPM Guide, please email CDSS at KatieA@dss.ca.gov (Not DHCS)

Scope of Practice

All providers should only provide services within their scope of practice. Please see Scope of Practice table, Appendix B.
XIII: PROGRESS NOTES

Action and Outcome

Progress notes are a summary description of what was accomplished or attempted at the time the service activity was provided. They provide a tool for measuring and monitoring “progress.” Progress notes can inform other team members and clinical supervisors about the work that’s been done to guide supplemental support or adjustments needed.

Progress notes must reflect how the service activity addressed the Individual’s Care Plan goal and relevant functional impairment.

Standards of Practice

Clinical Practices: The most important clinical elements to include in all progress notes are:

- The Individual’s or Child/Family’s recovery goal on the Care Plan
  - Helps to stay focused on how we support the wanted improvement for services
- The presenting purpose of your meeting with the Individual or Child/Family
- How the intervention (including EBPs, techniques, etc.) supported progress toward the recovery goal and reducing the impairment, restoring functioning, supported appropriate developmental progress, and/or prevented significant deterioration in an important area of life functioning outlined in the client plan.
- How the Individual/child/family responded to the intervention(s)
- Next steps (Plan) - What follow-up is needed between sessions? What will the Individual or child/family do in the community to continue to support their wanted improvement (recovery goal) until the next time they meet with you?

Processes to Support Engagement

The best way to support and continue building engagement is to stay focused on what the Individual or child/family wants in their lives. Progress notes are another part of our clinical practice that can help us to be aligned with the Individual or child/family’s hopes and dreams. Therefore, using notes as a trigger in tracking progress or set-backs helps to support services and recovery.

Frequency, Timing, Documentation

Progress notes are an essential element of documenting the golden thread of medical necessity. When the care plan goal focuses on a wanted functional improvement (“diminish the functional impairment”), the services are focused on supporting that improvement, and that’s reflected in the progress note, the golden thread of medical necessity and recovery support is strong.

DHCS requires that progress notes describe how services reduced the impairment(s), restored functioning, supported appropriate development progress, or prevented significant deterioration in an important area of life functioning outlined in the client plan. While not all components of medical necessity must be documented in a progress note, the progress note must clearly link the intervention to the identified functional impairment(s). (MHSUDS Information Notice No. 17-040)
Regulatory guidelines

Progress notes shall be documented at the frequency by type of service indicated below:

a) Every Service Contact:
   i. Mental Health Services;
   ii. Medication Support Services;
   iii. Crisis Intervention;
   iv. Targeted Case Management;

b) Daily:
   i. Crisis Residential;
   ii. Crisis Stabilization (1x/23hr);
   iii. Day Treatment Intensive; and

c) Weekly:
   i. Day Treatment Intensive: a clinical summary reviewed and signed by a QMHP;
   ii. Day Rehabilitation;
   iii. Adult Residential.

All entries must include:

• Every service activity is expected to have a separate corresponding note
• Each progress note page requires name and ID number of the individual
• Must include service date, total time in minutes, place of service, type of service activity
• The provider’s signature (handwritten or approved electronic equivalent) with County-recognized credential (appendix C)
• Provider license or registration number, when applicable
• Date signed
• All progress notes must be legible
• All reimbursable services should clearly document the reason for the service as it relates to the Care Plan goal and identified functioning impairment improvement.
• Progress notes that fail to provide adequate information about the intervention(s) and response are at risk of disallowance because it may be unclear if the service activity was provided.
• Timeliness of completion
  o Immediately following service provided is preferred, but no later than 5 business days
• When more than one clinician provides a service, progress notes must identify all clinicians participating, their credential, and their unique unduplicated role (for more information on two or more staff providing services during a single contact, see MHD Directive No. 2011-03)
• Correcting Notes:
  o Handwritten: strikethrough error, write correction, initial and date
  o Electronic: A new note is entered clarifying error/add additional information
• If there is a co-occurring substance use disorder, interventions are claimable as long as the primary focus of the interventions is to address the functional impairment(s) that is a result of the included mental health diagnosis. MHSUDS Information Notice No. 17-040
• Refer to “Medical Necessity, The Golden Thread, and Recovery (section III)” for information on cloned documentation.

Late Progress Notes
Notes completed after 5 business days must be identified as “Late Entry” in the body of the note
Travel Time

October 2013 State of California DHCS Mental Health Services Division Medi-Cal Billing Manual, 7.5.8 Travel and Documentation Time: Travel and documentation time is to be included in the service time and must not be claimed separately.

(p. 95) Can staff claim travel and documentation time at whatever service function rate, e.g., Mental Health Service (MHS), Case Management, etc., of the service provided?

- Yes. Travel and documentation time must be linked to the service provided.

(p. 99) Can FFP be claimed for travel time from one provider site to another provider site? From a staff’s residence to a provider site? From a staff’s home to a beneficiaries home?

- It depends.
- To claim Federal Financial Participation (FFP), travel time must be from a provider site to an off-site location(s) where Medi-Cal specialty mental health services are delivered.
- FFP cannot be claimed for travel between provider sites or from a staff member’s residence to a provider site.
- It is possible to claim for travel time between a staff’s home and the beneficiaries home as long as the MHP permits such activity & MHP travel guidelines are adhered to.
- **NOTE:** A “provider site” is defined as a site with a provider number, this includes affiliated satellite sites and school sites.

Chart Review / Record Review

Chart review is reimbursable when performed as part of the following services and service activities:

- Mental Health Services (assessment, plan development, collateral, rehabilitation, therapy)
- Targeted Case Management
- Medication Support Services, and
- Crisis Intervention

Chart review is included in the hourly, half day, full day, or calendar day rate for the following services and cannot be claimed separately:

- Day Treatment Intensive and Day Rehabilitation Services are claimed as either half or full days.
- Adult Residential, Crisis Residential, and Psychiatric Health Facility services are claimed based on calendar days. Crisis Stabilization services are claimed based on hours of time where each one-hour block that the beneficiary receives Crisis Stabilization services shall be claimed. Only twenty (20) hours of Crisis Stabilization services may be claimed in a 24-hour period.

In the case of a “no-show,” a provider may claim the time it took them to review an Individual’s record when the client no-shows as long as the provider documents the circumstances of the no-show. The time claimed for this service is reimbursable as plan development (CCR, title 9, section 1840.112(b)(3); title 22, section 51470(a); MHSUDS Information Notice 17-040)
Group Calculations

When services are being provided by two or more persons at one point in time, the number of staff group facilitators and the unique involvement of each shall be documented in the context of the mental health needs of the Individual. As a reminder, when providing Group services (i.e., two or more clients), the progress note must include the following items, otherwise it is at risk of disallowance:

- Type or name of group,
- Total group time, which is the participation time in group,
- Documentation time,
- Travel time,
- Number of clients,
- Number of clinicians and their names (if there is more than one clinician) with appropriate credentials,
- The specific involvement and time of involvement for each provider in the context of the Individual’s mental health needs,
  - When there is more than one provider, the time calculation for each provider is based on their individual involvement and participation rather than time spent in group,
- Each Individual’s response to group intervention provided.

**Calculation #1**: Group A had one clinician and 6 clients.

- Minutes of service time in group = 60 minutes
- The documentation time = 60 minutes
  (10 minutes documentation time per client multiplied by 6 clients)
- Travel time = 0 minutes
- The total group time = 120 minutes
- The total group time claimed per client = 20 minutes
  (120 minutes total group time ÷ 6 clients)

  ➢ Sample of Calculation Statement within Progress Note (one provider): Virginia Hamm, LMFT provided group therapy titled “Coping with Changes” to 6 children. The time spent in group = 60 minutes. Documentation time = 10 minutes per individual. Travel time = 0. Total group time = 120 minutes. 120/6 = 20 minutes per individual.

**Calculation #2**: Group B had 2 clinicians/providers and 8 clients for 90 minutes. Both clinicians/providers provided equal amounts of intervention time (90 minutes each).

- Provider 1: minutes of service time = 90 minutes
- Provider 2: minutes of service time = 90 minutes
- Provider 1 documentation time = 80 minutes
  (10 minutes per participant X 8)
- Provider 2 documentation time = 80 minutes
  (10 minutes per participant X 8)
- Travel time = 0 minutes
- Provider 1 total time = 170 minutes
- Provider 2 total time = 170 minutes

**Total Group Time**
If the group calculation for time claimed per Individual includes decimals (e.g., 21.25 minutes), then round down to the nearest whole number (e.g. 21)
**Provider 1 time claimed for each participant** 21 minutes  
(170 minutes ÷ 8 = 21.25 -> round down to 21)  
**Provider 2 time claimed for each participant** 21 minutes  
(170 minutes ÷ 8 = 21.25 -> round down to 21)

- Sample of Calculation Statement and intervention-response within Progress Note (each provider): Julie Jones LCSW and Anne Cole MHRS, provided a rehabilitation group titled “Women’s Relaxation” to 8 Individuals. Involvement in group = 90 minutes. Documentation time = 10 minutes per Individual. Travel time = 0 minutes. Total participation time = 170 minutes. 170/8 = 21.25 -> round down to 21.00 minutes for each Individual.

**Calculation #3:** Group C had 2 clinicians/providers and 8 clients for 90 minutes. Clinicians/providers participated for different amounts of time within the intervention.

- Provider 1: minutes of service time 90 minutes  
- Provider 2: minutes of service time 60 minutes  
- Provider 1 documentation time 80 minutes  
  (10 minutes per participant X 8)  
- Provider 2 documentation time 80 minutes  
  (10 minutes per participant X 8)  
- Travel time 0 minutes  
- Provider 1 total time 170 minutes  
- Provider 2 total time 140 minutes  
- Provider 1 time claimed for each participant 21 minutes  
  (170 minutes ÷ 8 = 21.25 – round down to 21)  
- Provider 2 time claimed for each participant 17 minutes  
  (140 minutes ÷ 8 = 17.50 – round down to 17)

- Sample of Calculation Statement within Progress Note (each provider):  
  o Provider 1 Note:  
    - Raquel Sheeran, PhD and Joshua Tree MHRS provided a rehabilitation group titled “Wellness Recovery Action Plan (WRAP)” to 8 Individuals. Involvement in group = 90 minutes. Documentation time = 10 minutes per Individual. Travel time = 0 minutes. Total participation time = 170 minutes. 170/8 = 21.25 -> round down to 21.00 minutes for each Individual.  
  o Provider 2 Note:  
    - Joshua Tree, MHRS and Raquel Sheeran, PhD provided a rehabilitation group titled “Wellness Recovery Action Plan (WRAP)” to 8 Individuals. Involvement in group = 60 minutes. Documentation time = 10 minutes per Individual. Travel time = 0 minutes. Total participation time = 140 minutes. 140/8 = 17.50 -> round down to 17.00 minutes for each Individual.

- **NOTE:** The samples above are the starting point of a group note. It is required to include specific involvement, additional interventions (if further engagement was needed), and response(s) from each Individual in group progress notes.
A. Qualifying Diagnoses

Per DHCS Annual Review Protocol for SMHS and Other Funded Programs FY19-20: “Ensure the beneficiary’s diagnosis is on the list of included outpatient diagnoses in BHIN IN No 20-043 and CCR, title 9, chapter 11, section 1830.205”

**Letters & Notices** from the CA Department of Health Care Services:

- **BHIN IN no 20-043** (7/8/2020) International Classification of Diseases, Tenth Revision (ICD-10) Included Sets
  - BHIN IN No 20-043: [Enclosure 1- ICD-10 Inpatient/Outpatient Diagnosis Codes and Descriptions](#)
  - Also refer to County of Santa Clara BHSD Memo “2020 ICD-10 Included Diagnosis” dated September 17, 2020
- For archived MHSUDS Information Notices, please go to the [DHCS website](#).
### B. Scope of Practice

It is expected that staff will only provide services based on their credential (i.e., license, education, training, and experience). Further limitations may be due to lack of experience in the specific service category or by an agency’s restrictions.

<table>
<thead>
<tr>
<th>Service Activities</th>
<th>Staff Who Can Provide this Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Case Management*</td>
<td>Physicians, psychologists, social workers, marriage &amp; family therapists, psychiatric-mental health nurse practitioner, registered nurses, licensed vocational nurses (LVN), licensed psychiatric technicians (LPT), occupational therapists registered/licensed (OTR/L), and paraprofessionals. Includes waived professionals, mental health rehabilitation specialists (MHRS), and interns/trainees.</td>
</tr>
<tr>
<td>• Assessment (except as noted below)</td>
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<tr>
<td>• Plan Development/ Treatment Plan **</td>
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<tr>
<td>• Collateral</td>
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<tr>
<td>• Rehabilitation (individual, group)</td>
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<tr>
<td>• Therapeutic Behavioral Services</td>
<td></td>
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<tr>
<td>• Crisis Intervention</td>
<td></td>
</tr>
<tr>
<td>• Assessment: Diagnosis</td>
<td>Licensed Practitioner of the Healing Arts (LPHA)</td>
</tr>
<tr>
<td>• Therapy (individual, family^^, group)</td>
<td></td>
</tr>
<tr>
<td>• Assessment: Psychological Testing</td>
<td>Licensed/waivered psychologists &amp; psychology interns</td>
</tr>
<tr>
<td>• Medication Support</td>
<td>Physicians, Psychiatric-mental health nurse practitioners, registered nurses, licensed vocational nurses, psychiatric technicians, and pharmacists.</td>
</tr>
</tbody>
</table>

* Pharmacist allowed to provide case management services

** LPHA signature required to authorize Treatment Plan

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See the next page for the Scope of Practice Crosswalk.
<table>
<thead>
<tr>
<th>Scope of Practice Crosswalk Grid (rev. 9/25/18)</th>
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<tbody>
<tr>
<td>LPHA = Licensed Practitioner of the Healing Arts</td>
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<td>Physician (MD)</td>
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<td>Assessment</td>
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<td>Case management</td>
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<td>Crisis Intervention</td>
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<td>Diagnosis, Five Axis</td>
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<td>Evaluation</td>
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<td>Intensive Care Coordination (ICC)</td>
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<td>Intensive Home Based Services (IHBS)</td>
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<td>Medication Support Services</td>
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<td>Psychological Testing</td>
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<td>Rehabilitation—Group</td>
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<td>Rehabilitation—Individual</td>
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<td>Therapeutic Behavioral Services (TBS)</td>
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<td>Therapy—Group</td>
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<tr>
<td>Therapy—Individual</td>
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<td>Therapy—Family</td>
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<tr>
<td>Treatment Plan</td>
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<tr>
<td>Treatment Plan Co-Signed by LPHA</td>
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<tr>
<td>Progress Notes w/o co-sign.</td>
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<tr>
<td>Progress Notes w/ co-sign.</td>
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<tr>
<td>May Co-sign O/P Prog. Notes</td>
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<tr>
<td>May Co-sign D/TX Daily Notes</td>
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<tr>
<td>May Co-sign D/TX Wkly. Notes</td>
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<tr>
<td>May Co-sign D/R Wkly. Summ.</td>
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<tr>
<td>May Co-sign Adult Res. Notes</td>
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<tr>
<td>May Co-sign Crisis Res. Notes</td>
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</tbody>
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**Notes:**
- #1 Clinical Psychologist
- #2 Licensed or Waivered
- #3 County Certified MHRS
- #4 Must Also Be County Certified MHRS
- #5 Need TBS Training & Certification prior to providing services
- #6 RN’s with less than 2 years of experience in MHD require all their work to be co-signed.
- #7 Ph.D./Psy.D. Interns permitted to conduct Psychological testing
- * Volunteers remain subject to scope of practice

**Paraprofessional > 2Yrs.**
- > 2Yrs.

**Paraprofessional < 2Yrs.**
- < 2Yrs.
C. County-Recognized Credential Identifiers

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<thead>
<tr>
<th>AMFT</th>
<th>APCC</th>
<th>ASW</th>
<th>LCSW</th>
<th>LPCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Marriage and Family Therapist</td>
<td>Associate Professional Clinical Counselor</td>
<td>Associate Social Worker</td>
<td>Licensed Clinical Social Worker</td>
<td>Licensed Professional Clinical Counselor</td>
</tr>
<tr>
<td>LPT</td>
<td>LVN</td>
<td>MD</td>
<td>MFT or LMFT</td>
<td>MFTT</td>
</tr>
<tr>
<td>Licensed Psychiatric Technician</td>
<td>Licensed Vocational Nurse</td>
<td>Medical Doctor (Psychiatrist)</td>
<td>Licensed Marriage and Family Therapist</td>
<td>Marriage and Family Therapist Trainee</td>
</tr>
<tr>
<td>MHRS</td>
<td>MSW Intern</td>
<td>OTR/L</td>
<td>PMHNP</td>
<td>PP+2</td>
</tr>
<tr>
<td>Mental Health Rehabilitation Specialist</td>
<td>Masters in Social Work Intern</td>
<td>Occupational Therapist Registered/Licensed</td>
<td>Psychiatric-Mental Health Nurse Practitioner</td>
<td>Paraprofessional &gt; 2 years</td>
</tr>
<tr>
<td>PP-2</td>
<td>PhD, PsyD Intern</td>
<td>PhD, PsyD, EdD Waiver</td>
<td>PhD, PsyD, EdD (Psychologist)</td>
<td>RN</td>
</tr>
<tr>
<td>Paraprofessional &lt; 2 years</td>
<td>Intern/Practicum Student</td>
<td>Waivered Clinical Psychologist</td>
<td>Licensed (Clinical) Psychologist</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>RPh</td>
<td>Registered Pharmacist</td>
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</tbody>
</table>

For others not listed, check with CSCBHSD QA Department

NOTE: At this time “PCC Trainee” and “EdD Intern” are not available credentials.

Credentials and Signature Guidelines

All recorded services, assessments, and plans must include:

- the signature of the person providing the service (or electronic equivalent),
- the person's type of professional degree, licensure, or job title,
- and the relevant identification number, if applicable.

Additionally, some documents require co-signing. These include:

- Day Rehabilitation Weekly Summary: written or co-signed by a Qualified Mental Health Professional (QMHP)
- Adult Residential Weekly Summary: written or co-signed by a QMHP
- Day Treatment Intensive Weekly Summary: reviewed & signed by LPHA
- Treatment Plan Authorization: reviewed & signed by LPHA
D. Prochaska and DiClemente’s Stages of Change Model & Intervention Strategies

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Characteristics</th>
<th>Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Not currently considering change: &quot;Ignorance is bliss&quot;</td>
<td>Validate lack of readiness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clarify: decision is theirs</td>
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<tr>
<td></td>
<td></td>
<td>Encourage re-evaluation of current behavior</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage self-exploration, not action</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain and personalize the risk</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Ambivalent about change: “Sitting on the fence”</td>
<td>Validate lack of readiness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clarify: decision is theirs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage evaluation of pros and cons of behavior change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify and promote new, positive outcome expectations</td>
</tr>
<tr>
<td>Preparation</td>
<td>Some experience with change and are trying to change: “Testing the waters”</td>
<td>Identify and assist in problem solving re: obstacles</td>
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<tr>
<td></td>
<td></td>
<td>Help patient identify social support</td>
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<td></td>
<td></td>
<td>Verify that patient has underlying skills for behavior change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage small initial steps</td>
</tr>
<tr>
<td>Action</td>
<td>Practicing new behavior for 3-6 months</td>
<td>Focus on restructuring cues and social support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bolster self-efficacy for dealing with obstacles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Combat feelings of loss and reiterate long-term benefits</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Continued commitment to sustaining new behavior</td>
<td>Plan for follow-up support</td>
</tr>
<tr>
<td></td>
<td>Post-6 months to 5 years</td>
<td>Reinforce internal rewards</td>
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<tr>
<td></td>
<td></td>
<td>Discuss coping with relapse</td>
</tr>
<tr>
<td>Relapse</td>
<td>Resumption of old behaviors: &quot;Fall from grace&quot;</td>
<td>Evaluate trigger for relapse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reassess motivation and barriers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan stronger coping strategies</td>
</tr>
</tbody>
</table>
E. Glossary

- **Chart Review or Record Review** - Prior to and in preparation for a service/appointment to gain more information on an individual; if following an appointment, records may assist in clinical decision making, including but not limited to formulating a diagnosis. To bill for this time, the review must be relevant in the context of the service you are providing or intended to provide. For more information on billing for chart or record review, please see IN 17-040, page 30, Item P “Claiming for Chart Review.” For documentation & billing specifications, you may also reference “Chart Review/Record Review” in Section XIII: Progress Notes.

- **Cost Center** - A term that refers to a specific program. Also known as the reporting unit.

- **Emergency Psychiatric Services (EPS)** - County of Santa Clara’s program that provides crisis stabilization services.

- **Institute for Mental Disease (IMD)** - A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental illnesses.

- **Interns/Trainees** - Undergraduate, graduate, and post-graduate students who are gaining experience, credit, or hours in conjunction with their academic program and discipline. They may provide the same service activities as their supervisor, but subject to the limitations of their discipline and academic program’s requirements.

- **Licensed Practitioner of the Healing Arts (LPHA)** - Includes physicians, licensed/waivered psychologists, licensed/waivered clinical social workers, licensed/waivered marriage & family therapists, licensed/waivered professional clinical counselors, and Psychiatric-mental health nurse practitioners.

- **Long-term Client/Beneficiary** - Any person open to our system over 60 days.

- **Long-term services and supports (LTSS)** - Services and supports provided to Individuals of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

- **Medically Necessary** - A determination that a specific service is clinically appropriate, necessary to meet the person's needs, consistent with the person's diagnosis, symptoms and functional impairments, is the most cost-effective option in the least restrictive setting, and is consistent with the BHSD’s medical necessity criteria and service selection guidelines.

- **Medical Necessity Criteria** - Criteria used to determine which services, equipment, and/or treatment protocols are required for the diagnosis or severity of illness that meets accepted standards of medical practice.

- **Mental Health Rehabilitation Specialist (MHRS)** - A credential issued by the County for paraprofessionals who have a bachelor’s degree plus four years of experience in a mental health setting. A master’s degree in a mental health related field may substitute for two years of experience. A two-year college degree plus six years of experience would also meet the minimum qualifications.
• **Paraprofessional** - An individual who provides mental health service activities but does not have a license/waiver/registration as a physician, psychologist, social worker, marriage & family therapist, professional clinical counselor, registered nurse, licensed psychiatric technician, or occupational therapist registered/licensed. If the individual does not have a bachelor’s degree in a mental health field and does not have at least two years of mental health experience, then all progress notes must be co-signed.

• **Practice Guideline(s)** - Clinical practice guidelines, protocols or service selection guidelines publicized by the BHSD and CBOs, guide clinical decisions regarding individuals’ access to covered services. These documents identify service eligibility criteria and the typical amount, scope and duration of covered services. For specific reference to Federal Guidelines, see “*Adoption & Application of Practice Guidelines for End Users*” in Section I.

• **Psychiatric Nursing Facility** - A skilled nursing facility that includes special treatment program services for persons with a mental illness.

• **Qualified Mental Health Professional (QMHP)** - Includes physicians, licensed/waivered psychologists, licensed/waivered clinical social workers, licensed/waivered marriage & family therapists, licensed/waivered professional clinical counselors, registered nurses, licensed vocational nurses, psychiatric technicians, and mental health rehabilitation specialists.

• **Quality Assurance (QA)** - The maintenance of a desired level of quality in a service or product, especially by means of attention to every stage of the process of delivery or production (are the right things done in the right way?) Measuring compliance with standards.

• **Quality Improvement (QI)** - “The use of a deliberate and defined improvement process...which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.” (R. Bialek, L. M. Beitsch, A. Cofsky, et al, unpublished data, 2009)

• **Significant Support Person** - In the opinion of the client or the staff providing services, a person who has or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of the client who is a minor, the legal representative of the client who is not a minor, a person living in the same household as the client, the client’s spouse or partner, and relatives of the client.

• **Waivered Professional** - A credential issued by the County for social workers, marriage and family therapists, and professional clinical counselors and by the California Department of Health Care Services for psychologists, which means the person may perform the same service activities and other services as a licensed professional in their discipline.
F. Citations, Resources & Links


California Code of Regulations (CCR), Title 9. *Rehabilitative and Developmental Services, Division 1*. Department of Mental Health, Adopt: Chapter 11. Medi-Cal Specialty Mental Health Services Subchapter 1. General Provisions, Article 1. General1810.345 (c) When appropriate based on the mental health condition of the beneficiary, the MHP of a beneficiary shall ensure that covered specialty mental health services described in Section 1810.247(a) are directed toward the maximum reduction of the mental disability and restoration of the beneficiary to the best possible functional level to the extent required by the Medi-Cal State Plan under rehabilitative mental health services. The Medi-Cal State Plan is California’s State plan for medical assistance as described in Title 42, Section 1396 and 1396a, United States Code.

California Department of Health Care Services (DHCS) MHSUDS Information Notices: [http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx](http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx)


Centers for Medicare & Medicaid Services, *CMS Probes* (C) (1) (ii)

Code of Federal Regulations, *Title 42, Chapter IV, Subchapter C, Part 438*


County of Santa Clara BHSD [Clinical Supervision Toolkit](#)

County of Santa Clara BHSD [Clinical Supervision Recommendations](#)

County of Santa Clara TCP [Webpage](#)


