CLAYTON CHAU, MD PhD
DIRECTOR/COUNTY HEALTH OFFICER

JEFFREY A. NAGEL, PH.D.
DIRECTOR
BEHAVIORAL HEALTH SERVICES

ANNETTE MUGRDITCHIAN, LCSW
DIRECTOR OF OPERATIONS
BEHAVIORAL HEALTH SERVICES

405 W. 5th STREET, 4th FLOOR
SANTA ANA, CA 92701
www.ochealthinfo.com

BEHAVIORAL HEALTH SERVICES
AUTHORITY & QUALITY IMPROVEMENT SERVICES
Quality Assurance & Quality Improvement Division

TO: Adult & Older Adult Behavioral Health (AOABH) & Children Youth and Prevention Behavioral Health (CYPBH) Services – Division Managers

FROM: Kelly K. Sabet, Authority & Quality Improvement Services, Behavioral Health Services

DATE: March 17, 2021

RE: Care Plan and Interim Care Plan Reminders & Frequently Asked Questions

---

AQIS Support Teams have received several questions from providers needing clarification pertaining to Care Plans & Interim Care Plans. The purpose of this document is to is inform providers of the DHCS regulations and provide clarification to some frequently asked questions. As a reminder, a Care Plan becomes valid from the date a qualified provider who is authorized to validate a Care Plan, (i.e. LPHA) signs the Care Plan, not from the date of the beneficiary/client/legal guardian's signature or the last required signature. However, beneficiary/client participation continues to be crucial in the development of Care Plans and should be documented appropriately. This practice is in accordance with the DHCS chart documentation standards. If a beneficiary/client and/or conservator is unable to sign the Care Plan in person, they can provide a verbal agreement over the phone or via a telehealth session. The provider will check "Signature obtained" on the Care Plan and document in a progress note that verbal agreement was obtained along with the reason for the missing signature(s). If the beneficiary/client and/or conservator is unable to provide a verbal agreement, providers will continue to check "Refused to sign" and document the reason for the missing signature(s). This information was previously provided to County and Contracted providers in the January and July 2020 QRTips.

Based on DHCS guidelines and feedback from the December 2019 DHCS Triennial audit, the Interim Care Plan (ICP) is an authorization for urgent services and must contain all the elements of the regular care plan Master Care Plan (MCP)with the exception of being less comprehensive. DHCS does not differentiate between an Interim Care Plan and the Master Care Plan regarding requirements for authorization of services. Historically, AQIS has incorporated some elements from the MCP into the Interim Care Plan, but not all. The 2019 DHCS Triennial Audit included a Plan of Correction for the ICP to include all required elements of the Master Care Plan. The following items must be documented in order to have a valid ICP:

1. Medical Necessity has already been established by a LMHP/waivered provider (Included Diagnosis on the Diagnosis Form, Impairments as a result of the mental health problem – CFE)
2. SMART Goals & Objectives

3. Proposed Types of Interventions
4. Detailed description of the interventions and which goals/objectives they will address
5. Proposed frequency and duration of interventions
6. Progress note documenting collaboration and/or agreement with the beneficiary/client with the Interim Care Plan
7. Signature of LMHP/waivered provider which will validate the plan
8. Signature of the Beneficiary/Client

Please note that a beneficiary/client signature is required, but not to activate the plan. The provider's signature, similar to the regular care plan, will activate the plan. For County EHR Clinics, since our current ICP cannot capture a signature for the form, we recommend that the LMHP or waivered provider sign the form to activate the plan. Then, you will need to print out a text version of the plan and get an external signature and scan the document back into the Interim Care Plan folder.

Frequently Asked Questions:

Question #1: Could we put "Refused to Sign" on all Care Plans? The reason being that providers may forget to get the CPs signed.

Answer #1: For best practice, it is important to make every effort to engage the beneficiary in developing the Care Plan.

- **For County EHR: Several scenarios about obtaining client's signature on Care Plan:**
  (1) If the client or caregiver is not present/unavailable to sign/give verbal consent for the document, and the 60 day due date is about to elapse, the provider should activate the care plan to be in compliance with DHCS regulations, by signing the plan and manually moving the beneficiary/client signature button to "Refused to Sign"; (2) If the beneficiary/client or caregiver is not present to sign the document, but is willing to give verbal consent, the provider will manually change the client signature button to "Signature Obtained" and sign the document; or (3) If the client or caregiver is present in the office and agrees to sign the care plan, the provider will obtain the signature through the EHR signature capture or external signature, move the client button to "Signature Obtained", and will sign the care plan. Please note that a progress note is required to document any of these transactions and any follow up steps if applicable (e.g., obtain physical signature when client or caregiver comes to the clinic).
- **For Contract providers' EHR system and paper charts:** This is straightforward. The care plan is valid when the provider signs and dates the plan.
- As a reminder, the care plan timeline begins on the date the provider signs. Your timeline should reflect this signature date. Please note your creation/service date of the Care plan doesn't mean your timeline starts unless you sign it that same day. Keeping correct timelines will help your chart stay in compliance.

Question #2: I'm concerned about the provider signing the plan early and providers not completing their other assessment paperwork (e.g., Psychosocial, CFE, Dx forms)

Answer #2: If the provider has all the necessary information and has completed all the assessment paperwork as well as formulate the CP, there should be no problem for the provider to sign the plan early **if the client is unavailable to sign or give verbal consent and the 60 days are about to expire.** If the provider has not completed the assessment paperwork (e.g., Psychosocial, CFE, Dx form), they should not sign the care plan until completing those forms. Without an assessment, we have not established medical necessity, which would put us out of compliance in 2 areas (medical necessity; based on an assessment establishing an included dx, impairments as a result of the dx and proposed treatments; care plan interventions based on the assessment and diagnosis). This workaround, provided by the state, to have the plan validated by the provider's signature requires all the assessment paperwork to be in place on the date of signature. The purpose of this workaround is to address only if the client or caregiver is causing the plan to be out of compliance regarding timeliness because of their unavailability or no-shows to sign the plan.

Question #3: Could the provider save the plan and wait until getting verbal consent or physical signature as long as the provider doesn't pass the 60 day or annual timeline?

Answer #3: Yes, the provider should save the plan and wait until the provider obtains either verbal/physical signature as long as it does not pass the 60-day timeline.

Question #4: If the beneficiary/client does not engage in treatment to provide a verbal/physical signature within the 60 day or annual timeline, should the provider sign the Care Plan and mark "Refused to Sign" for the client?

Answer #4: If the beneficiary/client is not able to sign the CP due to their mental illness, the provider would mark "Refused to Sign" and document this in the progress note. If the reason for lack of signature is not due to mental illness and the provider marks "Refused to Sign" for the client, the reason for this should be clearly documented in the progress notes. Subsequent follow ups should also indicate outreach to the beneficiary/client to try to obtain the signature. Reminder, if the beneficiary/client is engaged in treatment, the Care Plan should not be completed without the participation of the beneficiary/client.

Question #5: How does a provider identify a verbal statement of agreement for the Care Plan if a provider reviews the Care Plan through telephonic/telehealth services and the beneficiary/client agrees with the Care Plan?

Answer #5: The provider will mark "Client Signature Obtained" and document in the progress note that a verbal statement of agreement was obtained by the beneficiary/client. The provider will also need to document the beneficiary/client was involved in the development of the Care Plan.

Question #6: Does the provider need to obtain a physical signature after verbal consent is provided by the beneficiary/client for the Care Plan?

Answer #6: For best practice, a physical signature should be obtained for the Care Plan, however, due to the COVID-19 pandemic, there is no requirement to obtain the physical signature at a later date once verbal consent is provided.

Question #7: If providers are unable to obtain a physical signature on the ICP, how should this be identified on the ICP?

Answer #7: Providers should identify the reason for not being able to obtain the physical signature on the ICP within a progress note. If the reason for not obtaining the signature is due to the COVID-

19 pandemic, there is no requirement to obtain the physical signature at a later date if verbal consent has been provided. The progress note should indicate that the ICP included the participation of the beneficiary and or legal guardian/conservator. The progress note should also indicate the beneficiary and/or legal guardian/conservator provided verbal consent for the ICP.

ICP AND CP REMINDERS:

Elements needed before Validating ICP:

- Establish Diagnosis resulting impairments from MH DX
- Treatment that are likely to remediate the condition. What are the significant impairments that lead the provider to provide immediate services for the beneficiary?
- Provide 2 interventions
- ICP needs to have goals and objectives, types of services, frequency, amount, and duration
- Need to engage the beneficiary in developing the ICP and obtain signature.

Elements needed before validating CP:

- Complete assessment that covers all the 11 elements
- Establish diagnosis which needs to be completed by a LMHP/ waiver provider
- Need to have SMART goals and objectives
- **For county EHR:** complete CFE, diagnosis form, and psychosocial assessment

Please forward this memo to all county and contracted providers.

Any questions or concerns regarding this information can be directed to AQIS by email at aqissupportteams@ochca.com

Thank you,

Kelly K. Sabet, LCSW, CHC, DM

Kelly K. Sabet, LCSW, CHC
Division Manager, Authority and Quality Improvement Services

KS:sz