Clinical Standards for Client Plans

The process for developing an effective Client Plan is a collaboration between the provider and client/family. The Client Plan is a road map to a successful treatment outcome. While there are administrative elements to the Client Plan (for example, billing disallowance when not completed within timelines), creating the Client Plan is more than an administrative task.

The Client Plan should be written in realistic and attainable language, using the client's words as much as possible. After a thorough assessment, staff should help the client/family prioritize needs and focus attention on regularly offered services to meet those needs within a specified timeframe. As such, Client Plans should be written concisely, simply, and be easily understood by the client/family.

The following guidelines are provided for direction in navigating CCBH Client Plan functionality and to delineate the documentation standards for the Client Plan process.

CLIENT PLAN FAMILY FOLDERS

There are now Client Plan family folders which are separated out by service types. The new families will allow for programs to develop a Plan that is specific to the type of service being provided and will decrease the instances in which Plans are shared. While there will be fewer instances in which a Client Plan will be shared, it is still necessary to view any other open Plans and determine if duplicative services are being offered. Check with your Program Manager to determine the appropriate Client Plan family folder to choose.

CLIENT PLAN FAMILY INTERIM FOLDERS

Every Client Plan Family has an Interim Folder associated with it. CCBH always needs a place to "hold" progress notes, and the Interim Folder performs that function of holding notes prior to the opening the Client Plan folder. Interim Folders are created and used for services or documented activities from the client assignment date until the Client Plan Folder is opened and the plan developed. The Interim Folder is not to be used at any other time. Its purpose is to only provide a pre-Client Plan folder for holding notes within the first 30 days of admission to the program.

CLIENT PLAN FUNCTIONALITY IN CCBH

Initial Client Plans must be written and final approved, with all required signatures within 30 days of assignment to the program; date of assignment counts as day one. In CCBH, a Client Plan is valid for up to 365 days from the date it is created. Each program is responsible for tracking the Client Plan timelines to guarantee there are no lapses.

In addition to creating a new Client Plan, there are two other functions in CCBH – **Revise** and **Review.**

Revise

When a client has an active Client Plan in place and a change needs to be made (adding, editing, or updating), use the **Revise** function. The start date and end date of the Client Plan will remain the same and the current information will prepopulate.

Review

The Client Plan must be Reviewed at least annually. CYF programs are required to **Review** the plan at the UM cycle. When using the **Review** function, it establishes a new start and end date from the previous Client Plan and prepopulates the information for updating. Client Plans can be "administratively" updated and Final Approved at the annual due date if the client is not available for discussing, updating and signing the plan. An

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Interim Folder should never be used if a Client Plan folder expires. "Administratively" Final Approving a plan is a Never-Billable Activity. Only acceptable pre-Client Plan services are billable until the plan is discussed with and signed by the client.

FUNCTIONALITY OF PLANNING TIERS

- **Strength**
  - **a)** Select the **Strength** the client/family has indicated to be utilized to meet the **Objective**(s).
  - **b)** Detail in the narrative the Strength and how the client will apply and utilize the **Strength** to reach the **Objective**(s

- **Area of Need**
  - **a)** **Area of Need** shall describe the client's symptoms, behaviors, and functional impairments from the behavioral health assessment (BHA) and diagnosis form.
  - **b)** Use the client and/or family member(s) own words to individualize.
  - **c)** Do not copy/paste the clinical formulation or other large portions of narrative from the BHA into the narrative.
  - **d)** It is recommended to choose one general **Area of Need** and include numerically detailed needs in the narrative section.

- **Goal**
  - **a)** Select the **Goal** that automatically attaches to the selected **Area of Need**.
  - **b)** The narrative will prepopulate with the phrase, **"See Objective(s) Planning Tier"**.
  - **c)** You will only be required to add your Unit/Subunit and date to this planning tier.

- **Objective**
  - **a)** Select the **Objective** that will help the client achieve his or her desired outcome.
  - **b)** Detail in the narrative how the **Objective** is specific, measurable, and observable.
  - **c)** It is recommended to choose one general **Objective** and detail each **Area of Need** in the **Objective** narrative as a numerical list. Listed **Objectives** shall be specific, measurable, and observable and address all **Area(s) of Need**.
  - **d)** The standard text will offer a listing of three (3) stacked **Objective** narratives; you may delete or add additional **Objectives** and narratives.

- **Intervention**
  - a) Select the regular ongoing planned service codes.
    - i) Examples of regular ongoing service/**Intervention** codes include (but are not limited to) service codes: 20, 25, 26, 27, 30, 31, 32, 33, 34, 35, 36, 40, 50, 82, 83.
  - b) The **Intervention** narrative must be individualized to address the specific needs of the client.
  - c) **Interventions** must be tied to specific **Objective(s)** and include a description of specific strategies to be used and how the **Intervention** will diminish impairment or prevent deterioration (or, if under 21, allow developmental progress).
  - d) Frequency and Duration prompts are templated as standard text. For example, frequency is written: 1x/week or twice/month, etc. and duration is written: for the next 3 months or for the next 6 months, etc. General terms (i.e. "as needed" or "prn") are not permitted.
  - e) There are numerous services/**Interventions** that are **not** typically provided as ongoing services and can

be indicated as "Unplanned Services" on the progress note.

i) Examples of service codes that are not regularly provided include (but are not limited to) service codes: 9, 10, 11, 13, 14, 15, 28, 37, and 70

f) If you find during the course of treatment an **Intervention** is being used more regularly, the Client Plan shall be **REVISED** to add that Intervention and narrative.

REVISING/REVIEWING CLIENT PLANS (Not shared):

- The Tiers must be assessed and there should be changes made or a clear reason why no changes are being made to the Tier. Upon a **Revise** or a **Review** situation update narratives with the current client status.
- Always ***BEGIN*** narratives with Unit/Subunit and date with the most current information located on top. Remember to change the "Status Date" to the date you reviewed this information with the client.
- If information is still relevant, meets the documentation standards as described previously, and the Status is "Active," leave the information. If the information is still relevant but does not meet the documentation standards, re-write the narrative to meet the current standards.
- **Objective:** Document progress or status towards meeting the **Objective**. If the information is still relevant but does not meet the documentation standards, re-write the narrative to meet the current standards.
    - If the **Objective** has been met and only one **Objective** is written in the **Objective** Tier, change the Status to "Resolved." ***(KNOW THAT WHEN RESOLVING AN OBJECTIVE, ALL INTERVENTIONS LISTED UNDER THAT OBJECTIVE WILL ALSO BE RESOLVED AND INACTIVE.)***
    - If there are several **Objectives** numerically listed in the narrative and one **Objective** has been met, **DO NOT** change the Status to "Resolved" as this will inactivate all **Interventions** listed under the **Objective** Planning Tier. Beginning with the Unit/Subunit and date document in the narrative related to that specific **Objective** that the **Objective** has been met and why. The narrative of the met **Objective** may be removed at the next update.
- **Intervention:** Read the Intervention Planning Tier narrative(s) with the client/family.
    - If information is still relevant, meets the documentation standards as described previously, and the Status is "Active," leave the information.
    - If the information is still relevant but does not meet the documentation standards (i.e. not individualized, does not indicate every **Objective** utilizing the **Intervention**, does not provide strategies used, does not include Frequency/Duration, etc.), re-write the narrative to meet the current standards. Remember, to change the "Status Date" to the date you updated this information with the client.
    - If information is not relevant and the Status is "Active", change the Status to "Inactive" and indicate reasoning in the narrative.

SHARED CLIENT PLANS

Client Plan functionality in CCBH also allows for shared Plans when two or more of the same program types are providing services to a client/family at the same time. This occurrence should happen infrequently as there are specific service related Client Plan Families that separate service types. It is the expectation that programs will ***CHECK IN THE CLIENT ASSIGNMENTS TO SEE IF THE CLIENT IS CURRENTLY OPEN TO ANY OTHER PROGRAM*** and if so, work together to best meet the client/family needs and to support one another with the shared Client Plan in CCBH. When a Client Plan is shared between programs, each program must:

- Document in a way that demonstrates there is no duplication of services by documenting their own

narrative on each ***PLANNING TIER*** they will be utilizing. Most current narratives is placed on the top, beginning with Unit/Subunit and date.

- **Consult with one another** prior to ending a Client Plan or making other substantial changes (such as changing any Status on a Planning Tier) as it may create administrative burdens for the other program. For example, inactivating a Planning Tier will inactivate everything that is connected to that Planning Tier. Ending a Client Plan may leave another program without a valid Client Plan in place, and risk disallowance of services.
- **Revising SHARED Plan with a SHARED Objective:** Retain previous **Objective** narration to show client's progress or status. If **Area(s) of Need** or **Objective(**s) have been resolved, **DO NOT INACTIVATE PLANNING TIER**; indicate progress or information in the narrative section instead.
- **Reviewing SHARED Plan: *ONLY AFTER CONSULTATION WITH OTHER PROGRAM(S***). Remove **Area(s) of Need** and **Objective(s)** that has been Resolved.

PLANNING TIER AND STATUS DATES

To monitor progress and keep the Client Plan current, it is important to utilize the "Status" and "Status Date" functions in CCBH Client Plans. The Status selections primarily used are "Active," "Inactive," and "Resolved."

- "Inactive" Tiers allow for their deletion upon next use of the **Revise** or **Review** function; this is generally used when the information currently documented is not relevant.
- "Resolved" Tiers provide positive feedback to a client/family on their successful completion of part of their journey to recovery. Remember to always consult with other programs if there is a shared Client Plan and a Planning Tier will be made "Inactive" or "Resolved" ***AS THESE ACTIONS MAY IMPACT THE OTHER PROGRAMS.***
- Remove the "Inactive" and "Resolved" Tiers and narrative at the next update.

OBTAINING CLIENT SIGNATURES

Because the Client Plan is to be seen as a living document, it is likely within the first 30 days of admission to the program the Plan will be **Revised** on several occasions to capture the necessary information. The Initial Plan can be discussed with the client early on upon admission and agreed upon verbally, then created in CCBH and Final Approved with the "Document Client Non-Signature" option chosen, documenting in a Progress Note that the client/guardian agrees with services offered and was a part of creating the Plan. The requirement however is that the final Plan be completed, Final Approved and signed by client or guardian within the first 30 days.

When writing a new Client Plan or using the **Review** function in CCBH, it is required to obtain the client or guardian signature. The signature date on the hard copy signature page should be entered as the signature date in CCBH. If the client is unwilling to sign the Plan, selecting the "Document Client Non-Signature" option is acceptable with documentation in the Plan and in a Progress Note. Ongoing effort should be made and documented seeking to obtain the client's signature if at first unwilling to sign.

When using the **Revise** function for any "administrative" updates, a client signature may be obtained but is not required. If no signature is obtained, choose the "Document Client Non-Signature" option and document in the Plan and in a Progress Note the client's participation in and agreement with any changes.

Please note, if at admission to your program you will be sharing a Client Plan, using the **Revise** function to create your portion of the Plan, you are required to obtain all appropriate signatures within the 30 days from admission requirement (as if you were following the New Plan guidelines).

CLIENT PLAN Q&A

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Q: Do signature dates need to match for Client/Parent and Service Staff? And does this date need to match the date in CCBH?

A: The date the client (and parent/guardian, if applicable) signs the hard copy signature page is the date that should be entered for his/her signature dates in CCBH. The staff is required to sign the Client Plan in CCBH and the date is then automatically entered at Final Approval; the staff does not need to sign the hard copy page. As long as all signatures are dated within the acceptable timeframes, the Plan is valid.

Q: I have a client who is reaching the end of her UM Cycle and I have some additional information to add, but I see that the annual Plan date is due in the next few weeks for Review, what should I do?

A: In a case like this, it would be advised to **Review** the Plan instead of Revising. This way, the begin date of the Plan changes and you will avoid having to update the plan again in such a short time, also avoiding the possibility of oversight and having the Plan expire which could lead to the absence of a valid Client Plan and potential disallowances.

Q: I met with a client today for his annual update and client refused to sign. Would this be an example of a time when I can select the "Document Client Non-Signature" and provide an explanation? Also, although he refused to sign, can I still go in and update the Client Plan to reflect his needs for this year?

A: To sign off the EHR client signature, you would choose the "Document Client Non-Signature" option and document the reason the client did not sign. This information must be documented in your Progress Note along with client or guardian's agreement with services. You can go ahead and provide needed services to the client without his or her signature provided there is documentation with an explanation. The expectation, however, is that there will be continual attempts, when clinically appropriate, to discuss the signing of the Plan with the client, with these instances and client responses documented. If the client never agrees to sign but demonstrates openness and continual participation in services, your documented attempts to have them sign and their participation is enough to provide ongoing services until discharge.

Q: A new client comes to my program for services and I see that they have an open assignment at another program and that they also have an active Client Plan in CCBH. What do I do?

A: You must collaborate and coordinate care. With new Client Plan family folders being available for specific services, there is the possibility that you will not need to share a Plan. Check which Client Plan type family folder the current provider is using; if it is a different Client Plan type family folder than your assigned folder, you will view the current Plan and you are then to open a new Plan in your specified Client Plan Family Folder. If you have determined that you will be sharing a Client Plan family folder with another provider, you are to contact the other provider to assess if your services are duplicative. If they are, then you must decide who will close the client as duplicative services cannot be provided to the same client. If they are not duplicative services, you must view the active Client Plan and work with the client to determine the appropriate Planning Tiers. **Revise** the Plan to add your specific items and individualize the narrative to demonstrate how services are not duplicative. Remember to include your Unit/Subunit and date when adding to current narratives. Final Approve the Plan with all necessary signatures within the appropriate timelines. If client is new to your program, the program is still required to have signatures within 30 days.