

**Treatment Planning**

- ✓ Purpose
- ✓ Requirements
- ✓ Developing a Plan
- ✓ Updating a Plan
- ✓ Examples
- ✓ Claiming for the Service
- ✓ Using IBHIS

LACDMH Quality Assurance Unit – Policy and Technical Development Team – 6/17/20

**Standard Course of Action**

- 1. Assessing**
  - Complete a mental health assessment and establish medical necessity;
  - Complete an initial medication evaluation (if needed)
- 2. Planning**
  - Develop a client treatment plan (and if applicable, obtain medication consent) with the client;
- 3. Treating**
  - Provide treatment services to address the identified mental health condition and assist the client in reaching his/her objectives.

# Why do we develop treatment plans?



## Purpose of Treatment Planning

- Ensure a client's care is goal directed and outcome focused:
  - ✓ What are we working on and is it working?
- To guide treatment:
  - ✓ Develop the plan collaboratively with the client
  - ✓ Focus on the plan throughout treatment – this reinforces its value and prevents having to 'put out fires'
  - ✓ Be aware of the plan before the treatment session
- Ensure all payer requirements are met



# Treatment Plan Requirements



## Treatment Plan Requirements

**WHEN should it be completed:**

- Prior to initiating treatment services and at a minimum every 365 days
- Treatment services = services that address a client’s mental health needs and are NOT primarily for the purpose of:
  - ✓ Assessment
  - ✓ Plan Development
  - ✓ Crisis Intervention or
  - ✓ Linkage and referral if a need of immediate concern exists (in the first 60 days for newly active clients)

**WHAT should it address:**

- Addresses symptoms, behaviors, and/or impairments from the assessment

**WHO is involved:**

- Client / legal representative (as evidenced by the client’s signature)
- Significant support person, if applicable (as evidenced by their signature)
- Practitioner (AMHD signature & signature of staff within scope of interventions)

Reference: [LACDMH Policy 401.03 - Clinical Documentation for All Payer Sources](#) and the [Organizational Providers Manual](#)

## AMHD – Authorized Mental Health Disciplines

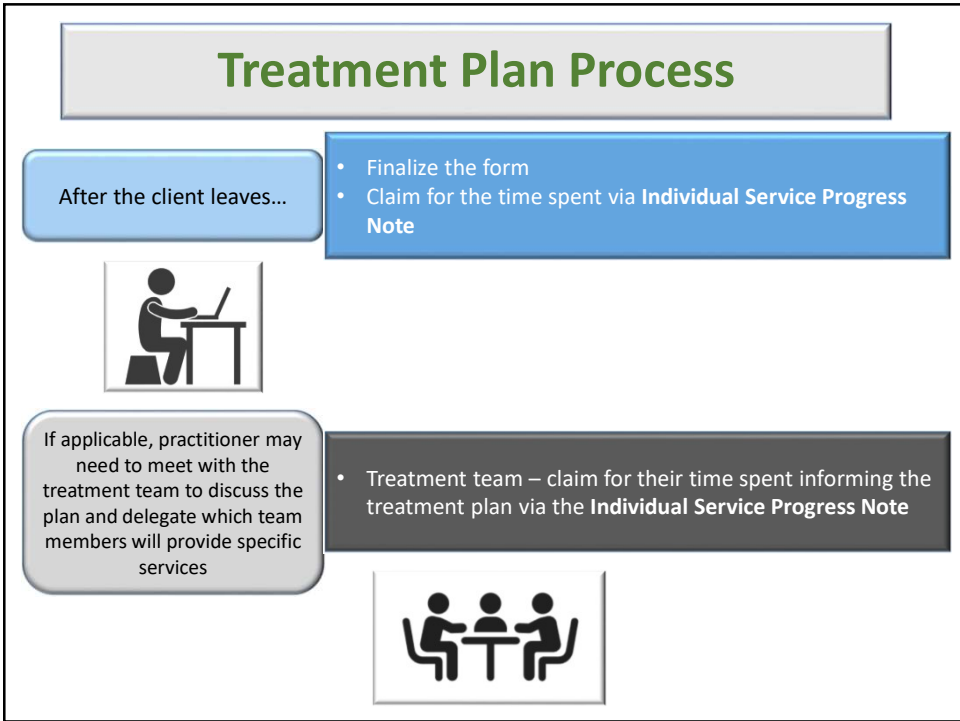
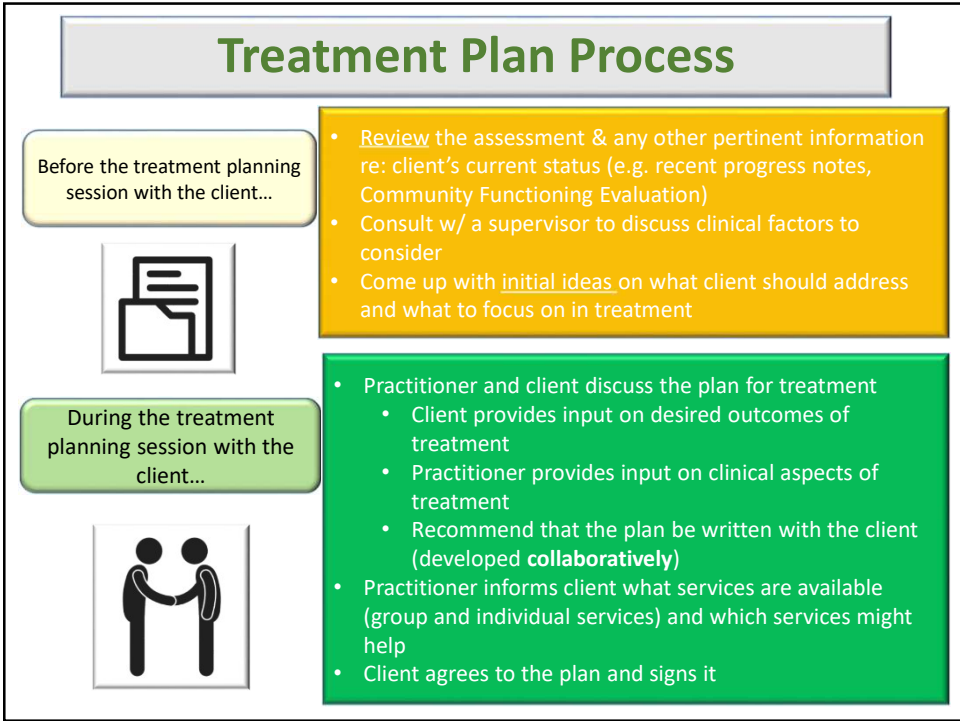
- AMHDs include:
  - ✓ Licensed or waived Psychologists (PhD/PsyD)
  - ✓ LCSW, ASW, or out-of-state licensed-ready waived Masters in Social Work
  - ✓ LMFT, AMFT, or out-of-state licensed-ready waived Marriage and Family Therapist
  - ✓ Licensed or waived Professional Clinical Counselor
  - ✓ Licensed Psychiatrists/Physician (MD/DO)
  - ✓ Nurse Practitioners (NP), registered Clinical Nurse Specialist (CNS), Registered Nurse (RN)
  - ✓ All students of these disciplines w/ co-signature
- The AMHD acts as the person who directs service provision



Reference: [Organizational Providers Manual](#)

## Developing the Treatment Plan






## 1 Long-Term Goal

What the client is hoping to achieve from treatment

✓What the client wants in his/her own words



Long Term Goal

"I want to feel better and get a job"

## 2 Problems

(To be addressed in the Treatment Plan)

The identified mental health need that will be addressed in treatment

✓“Included” Primary diagnosis

✓Impairments due to the Primary diagnosis

- (e.g., Unemployment, homelessness)

▼ **Problem: Generalized anxiety disorder**

▼ **Goal**

▼ Reduce anxiety

▼ **Objective**


▼ Client will reduce anxious symptoms from a GAD-7 score of 18 (severe) to 8 (mild)

▼ **Intervention**

Practitioner will provide individual therapy to identify and modify his anxiety provoking cognitive distortions

### 3 Goals

The broad intention of treatment

- ✓ Usually the opposite of the problem 
- ✓ As written, this should be about 2-5 words in length

▼ Problem: Generalized anxiety disorder

▼ Goal

▼ Reduce anxiety

▼ Objective




▼ Client will reduce anxious symptoms from a GAD-7 score of 18 (severe) to 8 (mild)

▼ Intervention

Practitioner will provide individual therapy to identify and modify his anxiety provoking cognitive distortions

### 4 Objectives

How the goal is measured to know if treatment is working

- ✓ Develop Objectives that are:
  1. Related to the client’s mental health needs (symptoms/behaviors/impairments documented on the client’s assessment) 
  2. Measurable 
  3. Written in a way that makes sense to the client 

▼ Problem: Generalized anxiety disorder

▼ Goal

▼ Reduce anxiety

▼ Objective

▼ Client will reduce anxious symptoms from a GAD-7 score of 18 (severe) to 8 (mild)

▼ Intervention

Practitioner will provide individual therapy to identify and modify his anxiety provoking cognitive distortions

REFERENCE SLIDE

## Sample Objectives

Pause the video if you want to review these examples

Client will reduce depressive symptoms from a PHQ-9 score of 17 (moderately severe) to <4 (minimal)

Client will increase daily independent living skills from 0x to 2x per day

Client will obtain a part-time job within 6 months

Client will obtain stable permanent housing



Client will increase social activities from 0x to 3x per week

Client will increase showering from 1x per week to 4x per week

## 5 Interventions

This is what practitioner will do to help the client attain his/her objective

✓ When developing Interventions, make sure the client understands...

1. What the practitioner will be doing
  - Description of the intervention 
2. Why the practitioner is doing it
  - To address client's mental health need 
3. How often the practitioner will be doing it
4. When the practitioner will be done (if duration less than a year)

▼ Problem: Generalized anxiety disorder

▼ Goal

▼ Reduce anxiety

▼ Objective

▼ Client will reduce anxious symptoms from a GAD-7 score of 18 (severe) to 8 (mild)

▼ Intervention

Practitioner will provide individual therapy to identify and modify his anxiety provoking cognitive distortions



## Sample Interventions

Pause the video  
if you want to  
review these  
examples

### Type of Service: MHS

- Provide **individual rehab** to teach and model life skills (e.g., communication, budgeting, relaxation, self-management) to improve independence
- Provide **individual therapy** using CBT to identify and modify client's anxiety-provoking thoughts and beliefs in order to reduce anxiety
- Provide **collateral services to client's mother** on how to identify when client is becoming anxious and how to assist client with using his anxiety-reducing skills learned in therapy

### Type of Service: TCM

- **Identify and evaluate** available housing resources, **assist** with application process, work with housing agency and **monitor linkage**
- **Identify, link, and monitor** available employment resources and **assist** with application process
- **Link** client to available medical resources and **assist** with **monitoring** and **following up** with appointments

## Updating a Treatment Plan



## Annual vs. Update Treatment Plan

- **Annual Client Treatment Plan (CTP)**

- ✓ The initial treatment plan created after an assessment and completed prior to the initiation of treatment
- ✓ An Annual CTP is developed minimally every 365 days from the date of the last Annual CTP

Plan Type	Plan Date	End Date	MSS	MHS	TCM	Status
Annual	05-04-2020	05-04-2021		MHS	TCM	Final
Annual	06-03-2019	06-02-2020		MHS		Final


- **Update Client Treatment Plan**

- ✓ The treatment plan created when new objectives or interventions are added to an existing Annual CTP

Plan Type	Plan Date	End Date	MSS	MHS	TCM	Status
Update	05-01-2020	10-27-2020			TCM	Final
Annual	10-28-2019	10-27-2020			TCM	Final

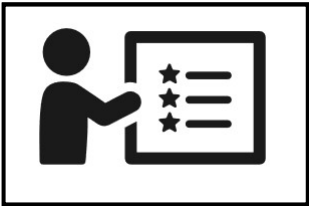
## Update Client Treatment Plan

- **Things to remember:**

- ✓ Any new objectives would still need to address the mental health needs documented on the client's assessment (or assessment addenda)
  - If any significant changes in the client's condition occur during the course of treatment (e.g. hospitalizations, new trauma, etc.), the treatment plan should be reviewed and updated
- ✓ New signatures from the client/legal representative, significant support persons, if applicable, and staff are required 
- ✓ An Update plan will not change the Plan End Date

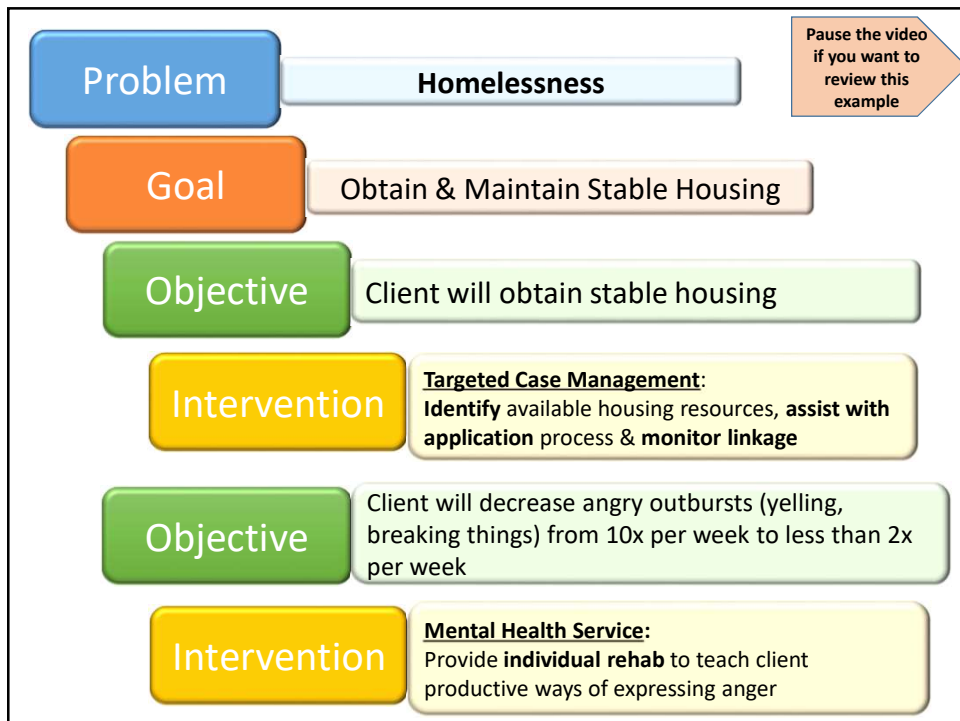
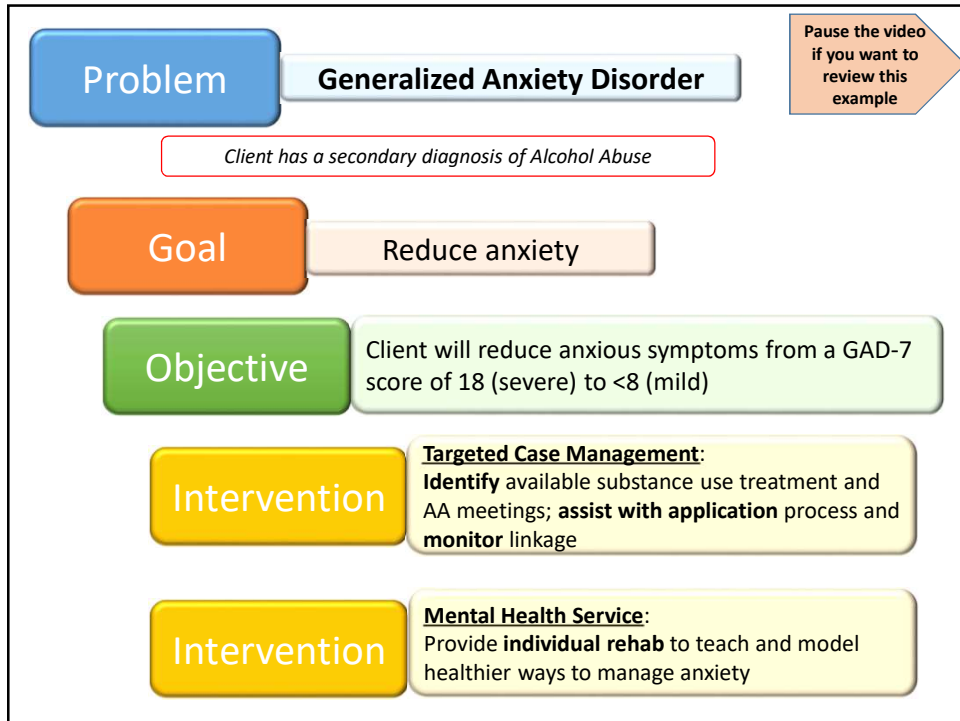
Plan Type	Plan Date	End Date
Update	05-01-2020	10-27-2020
Annual	10-28-2019	10-27-2020

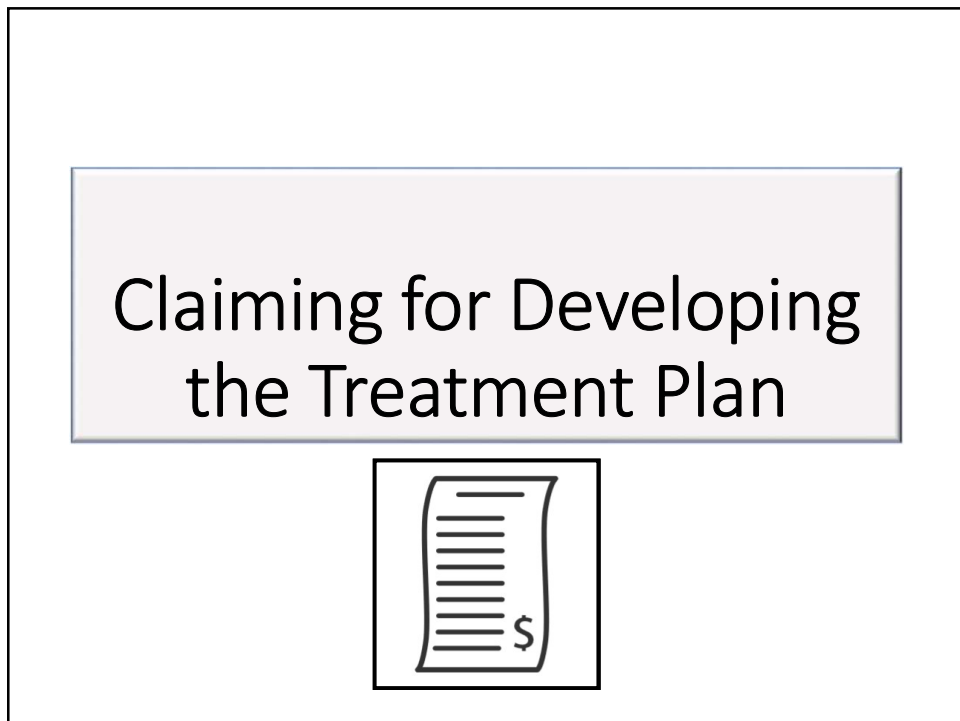
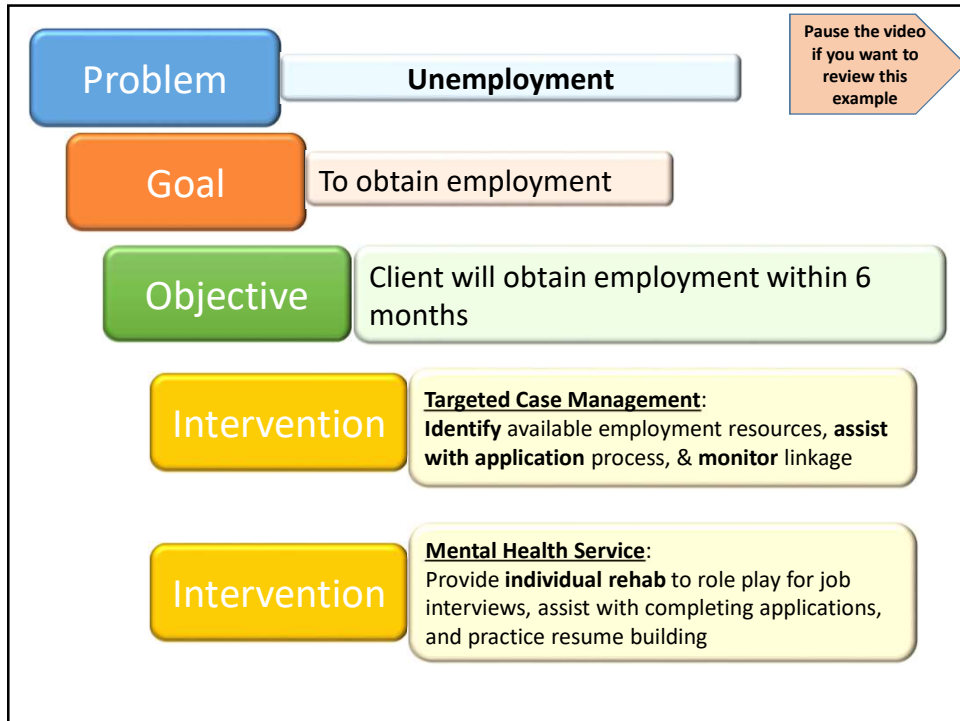
# Treatment Plan Examples




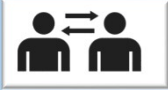


Pause the video if you want to review this example

Problem	Major Depression
Goal	Improve mood
Objective	Client will reduce depressive symptoms from a PHQ-9 score of 17 (moderately severe) to <4 (minimal)
Intervention	<b>Mental Health Service:</b> Provide <b>individual therapy</b> using CBT to identify and modify client's negative feelings of worthlessness and reinforce active problem-solving skills in order to strengthen self-confidence and improve mood
Intervention	<b>Mental Health Service:</b> Provide <b>collateral</b> services to client's spouse so that spouse can assist client better with using his problem-solving skills at home





## Progress Note

- Services provided to clients are documented using a progress note (**Individual Service Progress Note**) 
- Within the progress note:
  - ✓ Select the procedure code based on the service provided
  - ✓ Enter the duration of the service
    - ✓ **Face to Face Time** = time spent seeing the client 
    - ✓ **Other Time** =
      - time spent providing a service to a significant support person
      - time spent writing the progress note and completing other applicable forms 
      - travel time, if this applies 

Outpatient SMHS covered & provided by directly-operated (reimbursable services)		
Mental Health Services (MHS)	Individual, group, collateral or family-based interventions to restore a client's functioning and ability to remain in the community with goals of recovery and resiliency	<ul style="list-style-type: none"> <li>✓ Assessment</li> <li>✓ Plan Development</li> <li>✓ Therapy</li> <li>✓ Rehabilitation</li> <li>✓ Collateral</li> </ul>
Intensive Home Based Services (IHBS)	An intensive form of MHS that is predominantly delivered in the home, school or community. IHBS is specifically intended for children/youth who are already receiving Intensive Care Coordination.	<ul style="list-style-type: none"> <li>✓ Rehabilitation</li> <li>✓ Collateral</li> </ul>
Targeted Case Management (TCM)	Services that assist a client in accessing needed ancillary resources (e.g. medical, alcohol/drug treatment, vocational)	<ul style="list-style-type: none"> <li>✓ Assessment</li> <li>✓ Plan Development</li> <li>✓ Referral and Related Activities</li> <li>✓ Monitoring &amp; Follow-Up</li> </ul>
Intensive Care Coordination (ICC)	An intensive form of TCM that facilitates the assessment, planning and coordination of services. ICC is specifically intended for children/youth who are involved in multiple child serving systems and require cross-agency collaboration through a Child and Family Team	<ul style="list-style-type: none"> <li>✓ Planning &amp; Assessment of Strengths &amp; Needs</li> <li>✓ Reassessment of Strengths &amp; Needs</li> <li>✓ Referral, Monitoring, and Follow-Up Activities</li> <li>✓ Transition</li> </ul>
Medication Support Services (MSS)	Prescribing/furnishing, administering and monitoring psychiatric medications to reduce a client's mental health symptoms	<ul style="list-style-type: none"> <li>✓ Evaluation of the Need for Meds</li> <li>✓ Evaluation of Clinical Effectiveness &amp; Side Effects of Meds</li> <li>✓ Obtaining Information Consent</li> <li>✓ Medication Education</li> <li>✓ Collateral</li> <li>✓ Plan Development</li> </ul>
Crisis Intervention (CI)	Unplanned and expedited services to address a condition that requires more timely response than a regular appointment in order to assist a client to regain/remain functioning in the community.	<ul style="list-style-type: none"> <li>✓ Assessment</li> <li>✓ Therapy</li> <li>✓ Collateral</li> <li>✓ Referral</li> </ul>

Outpatient SMHS covered & provided by directly-operated (reimbursable services)		
<b>Mental Health Services (MHS)</b>	Individual, group, collateral or family-based interventions to restore a client's functioning and ability to remain in the community with goals of recovery and resiliency	✓ Plan Development - <i>developing a treatment plan and/or monitoring the client's progress related to mental health services</i>
<b>Targeted Case Management (TCM)</b>	Services that assist a client in accessing needed ancillary resources (e.g. medical, alcohol/drug treatment, vocational)	✓ Plan Development - <i>developing a treatment plan and/or monitoring the client's progress related to accessing ancillary resources</i>
<b>Intensive Care Coordination (ICC)</b>	An intensive form of TCM that facilitates the assessment, planning and coordination of services. ICC is specifically intended for children/youth who are involved in multiple child serving systems and require cross-agency collaboration through a Child and Family Team	<ul style="list-style-type: none"> <li>✓ Planning &amp; Assessment of Strengths &amp; Needs – <i>includes ensuring that plans from any of the system partners are integrated to comprehensively address the identified goals and objectives; determining the needs of the child and family, including strengths and underlying needs</i></li> <li>✓ Referral, Monitoring, and Follow-Up Activities – <i>includes evaluating the effectiveness of the plan, reworking the plan, monitoring to ensure that the youth's needs are met</i></li> </ul>
<b>Medication Support Services (MSS)</b>	Prescribing/furnishing, administering and monitoring psychiatric medications to reduce a client's mental health symptoms	✓ Plan Development - <i>developing a treatment plan and/or monitoring the client's progress related to medication</i>

Outpatient SMHS covered & provided by directly-operated (reimbursable services)		
<b>Mental Health Services (MHS)</b>	Individual, group, collateral or family-based interventions to restore a client's functioning and ability to remain in the community with goals of recovery and resiliency	✓ Plan Development H0032
<b>Targeted Case Management (TCM)</b>	Services that assist a client in accessing needed ancillary resources (e.g. medical, alcohol/drug treatment, vocational)	✓ Plan Development T1017
<b>Intensive Care Coordination (ICC)</b>	An intensive form of TCM that facilitates the assessment, planning and coordination of services. ICC is specifically intended for children/youth who are involved in multiple child serving systems and require cross-agency collaboration through a Child and Family Team	<ul style="list-style-type: none"> <li>✓ Planning &amp; Assessment of Strengths &amp; Needs</li> <li>✓ Referral, Monitoring, and Follow-Up Activities</li> </ul> T1017HK
<b>Medication Support Services (MSS)</b>	Prescribing/furnishing, administering and monitoring psychiatric medications to reduce a client's mental health symptoms	✓ Plan Development H2010

If the plan development is provided during a MHS activity (e.g. assessment, therapy, rehab), the time spent can be added to the duration of that MHS activity

## Plan Development Scenarios

During session w/ client, social worker developed the treatment plan and added individual and group therapy to the plan.	H0032
Medical Case Worker met w/ client for individual rehab. During the session, the treatment plan was updated to include a group rehab intervention.	H2015
Psychologist met w/ client and parent to complete the assessment and treatment plan.	90791
Community Worker completed the Community Functioning Evaluation w/ client and added an intervention related to finding housing resources to the client's treatment plan.	T1017
Therapist and case manager meet to discuss client's lack of progress in treatment and updates to client's living situation (client now lives w/ paternal grandmother). Based on increased behaviors and change in caregiver, therapist stated that individual rehab w/ the case manager and collateral sessions w/ the therapist will be added to the client's treatment plan. Case manager suggested adding targeted case management to assist family w/ finding parenting resources in the community.	Therapist: H0032 Case Manager: T1017
During CFT Meeting, client, family, and treatment team agreed that Rehab Specialist will start meeting with the client 2x per week, and Parent Partner will meet with family 1x per week. Treatment Plan was updated to include these services.	T1017HK

## Progress Note Example 1

Pause the video if you want to review this note

Practitioner met with the client for the [purpose of developing the treatment plan \(refer to treatment plan dated 5/1/20\)](#). **Reimbursement**

Client and practitioner [agreed that individual therapy and targeted case management would be helpful in addressing client's anxiety and assisting client with obtaining employment resources.](#) **Clinical**

[Client signed the treatment plan.](#) **Legal**

At the next session on 5/8/20, practitioner and client will meet to begin individual therapy sessions. Practitioner will consult with the case manager to discuss client's needs related to employment.

**Procedure Code:** H0032  
**Face to Face:** 36 minutes  
**Other Time:** 30 minutes  
*(includes writing the progress note and documenting on the treatment plan form)*



## Progress Note Example 2

Pause the video if you want to review this note

Practitioner met with the client for the purpose of conducting an assessment and developing a plan for treatment. Refer to the Adult Full Assessment dated 5/3/20 and DMH Client Treatment Plan dated 5/3/20. **Reimbursement**

Client was open to services and forthcoming with sharing information about himself. Client and practitioner agreed to group rehab services to help client learn better communication skills, individual therapy to address trauma, and targeted case management to assist with finding stable housing. **Clinical**

Practitioner will complete referral to rehab group and consult with group leaders. At next session, practitioner and client will begin individual therapy sessions.

Time not billed: Reviewing consent for services, HIPAA, and confidentiality. Client signed all necessary forms. **Legal**

**Procedure Code:** 90791

**Face to Face:** 79 minutes

**Other Time:** 66 minutes

*(includes writing the progress note and documenting on the assessment and treatment plan forms)*

## Progress Note Example 3

Pause the video if you want to review this note

**Goal:** Client will decrease depressive symptoms from a PHQ-9 score of 19 to a 4 or less.

**Intervention:** Met with the client for the purpose of conducting an individual therapy session. **Reimbursement**

Administered the PHQ-9 – client's current score is 19 (moderately severe). Client continues to endorse feeling depressed, feeling like a failure, difficulties falling asleep, and fatigue. Discussed lack of progress towards reducing depressive symptoms. Inquired whether client would be open to adding group interventions to the client's plan. Also discussed whether client was open to a referral for an initial medication evaluation. Focused on challenging client's underlying belief related to worthlessness, and modifying his tendency toward global self-rating. Assisted client in using statements to rate his behaviors and not his entire self. Practiced using problem-solving skills with the client to help him effectively address his triggers.

**Response:** Client will continue to practice using statements to rate his behavior rather than his entire self and to continue practicing problem-solving skills. **Clinical**

Client agreed to trying group rehab to learn more problem-solving and coping skills. Client also agreed to speak to the psychiatrist to determine if medications might help. Client signed updated treatment plan. **Legal**

**Plan:** To continue working on modifying self-defeating beliefs and strengthening problem-solving skills. Practitioner will complete a referral for a CBT group which will start on 6/8/20. Group rehab was added to client's treatment plan. Practitioner made an appointment for client for an initial medication evaluation with Dr. X on 6/10/20.

**Procedure Code:** 90837

**Face to Face:** 68 minutes

**Other Time:** 21 minutes *(includes writing the progress note and documenting on the treatment plan)*

## Progress Note Example 4

Pause the video if you want to review this note

**Participants:** M. Young (client's therapist), S. Smith (client's case manager) and Dr. X (client's psychiatrist)

**Reason for consultation:** Client has not made progress towards treatment goals and was just released from the hospital after expressing suicidal ideation. Team to discuss modifications and new interventions to treatment plan.

**Pertinent information shared/discussed:** Treatment team met to discuss needed modifications to client's treatment plan. Reimbursement

Therapist reviewed information from the hospital regarding client's presentation. Therapist informed team about client's history of self-harm and worsening depressive symptoms since learning about her father's cancer. Prior to the hospitalization, client's mother informed case manager that client hasn't been sleeping and appears more withdrawn at home.


Team members discussed various options for addressing symptoms including changing her medications and adding family and collateral sessions to the client's treatment plan. Clinical

**Action plan as a result of the consultation:** Psychiatrist will meet with client and mother today to evaluate the need for psychotropic medication and discuss medication options. Therapist to meet with client and mother afterwards to discuss adding family therapy with the writer and collateral sessions with the case manager to the treatment plan and obtain the necessary signatures. Legal

<b>Therapist:</b> Service Code: H0032 Face to Face Time: 0 (client was not present) Other Time: 38 minutes (includes time spent consulting with the team and documentation time)	<b>Case Manager:</b> Service Code: H0032 Face to Face Time: 0 (client was not present) Other Time: 35 minutes (includes time spent consulting with the team and documentation time)	<b>Psychiatrist:</b> Service Code: H2010 Face to Face Time: 0 (client was not present) Other Time: 37 minutes (includes time spent consulting with the team and documentation time)
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*It is especially important to update the tx plan when there are significant changes in the client's status (e.g. hospitalization, new trauma, worsening symptoms).*

# Form / Widget in IBHIS



## DMH Client Treatment Plan Widget

Plan Name	Plan Type	Plan Date	End Date	MSS	MHS	TCM	Status
1905V, C, Run	Annual	05-04-2020	05-04-2021		MHS	TCM	Final
1905V, C, Run	Annual	06-03-2019	06-02-2020		MHS		Final

LAUNCH DMH Treatment Plan

1. Most recent treatment plan will be displayed on the first line
2. Color of the “End Date” will let you know if the plan is **current** or **expired**
3. Types of Services noted in the plan
4. Status of the form
  - ✓ Final – plan has been finalized / signed by the practitioner
  - ✓ Draft – plan has not been finalized and has not been signed by the practitioner
  - ✓ Pending - plan is waiting to be approved / co-signed by a supervisor or AMHD
5. Launch the form directly from this widget

## DMH Client Treatment Plan

- Pay close attention to pop-up messages

myAvatar 2020 - Treatment Plan

Is this an UPDATE to an existing plan?

Yes No

**Yes** – You are adding new objectives and/or interventions to the current/existing Annual

**No** – You are creating a new Annual Plan (starting over)

myAvatar 2020 - Client Treatment Plan

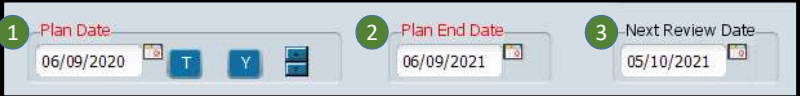
Default From Previous

05/19/2020 Annual

OK Cancel

**Default from Previous** – this means you want to bring in information from the most current/existing plan. This is used when creating an Update Client Treatment Plan.

## DMH Client Treatment Plan

- Dates**  


The screenshot shows three date selection fields: 1. Plan Date: 06/09/2020; 2. Plan End Date: 06/09/2021; 3. Next Review Date: 05/10/2021. Each field has a calendar icon and a dropdown arrow.
- Plan Date** = date treatment plan was created
  - Plan End Date** = automatically defaults to 365 days after the plan date
    - ✓ This date cannot be changed to a later date
  - Next Review Date** = automatically defaults to 1 month before the Plan End Date
    - ✓ Practitioner will receive a reminder in his/her My To Do's (if practitioner is listed as a participant)

## DMH Client Treatment Plan

- Problems to include in the client's plan**
  - ✓ Only select problems that are the identified mental health need(s) that will be addressed in treatment

Problems		
	Include in this plan?	Problem
4	<input checked="" type="checkbox"/>	Depressive disorder (SNOMED-35489007)
5	<input type="checkbox"/>	Schizoaffective disorder (SNOMED-68890003)
6	<input checked="" type="checkbox"/>	Oppositional defiant disorder (SNOMED-18941000)
7	<input type="checkbox"/>	Parent/child conflict (SNOMED-14345008)
8	<input type="checkbox"/>	Family history of alcohol abuse and dependence (SNOMED-266890009)

Excluded diagnoses will not be selected as problems to include in the treatment plan

## DMH Client Treatment Plan

- Signatures
  - ✓ Client/legal representative and significant support person(s) will sign the treatment plan using the signature pad
  - ✓ Practitioner(s) will sign the treatment plan by finalizing the form and entering their electronic signature

1	Role	Staff ID	Participant Name	Notification	Treatment Plan Participant Authorization	Signature on File
1	1. Client (1)		Test, Client	No (N)	Sign	Signature on File (1)

- ✓ **Signature on File** = client/legal representative and/or significant support person(s) signed a paper copy of the treatment plan and plan was scanned into IBHIS
- ✓ If unable to obtain signatures, need to provide a justification/explanation

**Reason for lack of client/legal representative signature (Only applies to rare situations)**

Client/Legal Representative Participation


Client/Other Refused/Unable to Sign

Client/Other is Unavailable to Sign

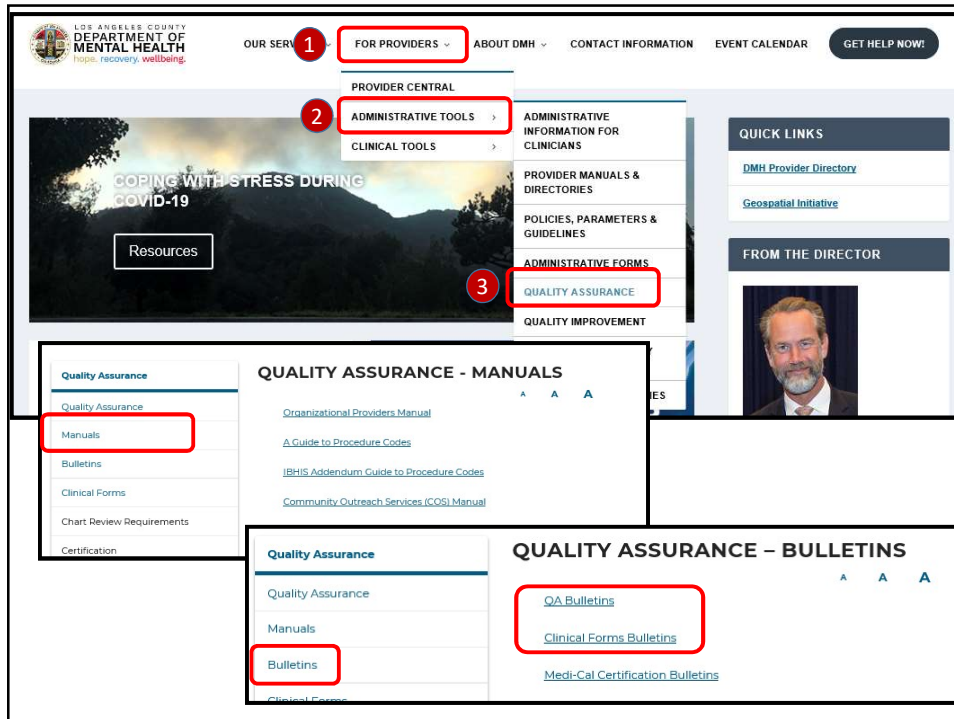
**Justification/Explanation**

Client understands and verbally agreed to the plan but is not able/available to sign due to procedures in place in response to ~~COVID~~ COVID-19 public health emergency.

## Let's go into IBHIS...



- DMH Client Treatment Plan
  - ✓ Annual
  - ✓ Update
- DMH Client Treatment Plan (Last 2 Years) Widget
- Treatment Plan Report
- Problem List
- Scheduling Calendar
- Individual Service Progress Note



## Treatment Plan – Resources

- [Organizational Providers Manual](#)
  - ✓ **What it is:** Provides information about the Short-Doyle/Medi-Cal claiming and documentation system
  - ✓ **Where to go:** DMH Website > For Providers > Administrative Tools > Quality Assurance > Manuals
- [LACDMH Policy 401.03 - Clinical Documentation for All Payer Sources](#)
  - ✓ **What it is:** Provides policy and procedures for clinical record documentation related to the delivery of SMHS within DMH
  - ✓ **Where to go:** DMH Website > For Providers > Administrative Tools > Policies
- [QA Bulletin 17-10: Client Treatment Plan Reminders](#)
  - ✓ **What it is:** Provides client treatment plan requirements and guidelines for developing plans and obtaining client/legal representative signatures
  - ✓ **Where to go:** DMH Website > For Providers > Administrative Tools > Quality Assurance > Bulletins