COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

Edition 2009-03

Program Support Bureau
550 S. Vermont, 10th Floor
Los Angeles, CA 90020

March 10, 2009

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CLINICAL RECORDS BULLETIN

Announcements

All Service Areas have received training on the revised Co-Occurring Disorder (COD) forms at their respective SA QA meetings. It is the expectation of the Department that the forms are now in use Department-wide for all adult clients. Please see CR Bulletin 2009-01 "Revisions to Adult Initial Assessment and All Co-Occurring Disorders Forms" if you need detailed information regarding the forms. Additional questions regarding Co-Occurring Disorders may be directed to John Sheehe at jsheehe@dmh.lacounty.gov.

MH 636 - Client Care Coordination Plan

Revised Form Available on Internet

(http://dmh.lacounty.gov/Forms.asp—see CCCP/SFPR)

DMH Official Form Usage

Directly Operated Clinics: *must* use this form, when applicable, in its original format.
Contractors: *must* use this form, when applicable, without alteration in its original format.

The Client Care Coordination Plan (CCCP) has been revised to emphasize client care, reduce duplication of documentation, and enable simplicity in form completion. Over the past several years, staff from the Program Support Bureau has worked with ACHSA members, the Psychiatric Social Workers Association, and many clinic and administrative staff to revise the CCCP and address clinical needs as well as reimbursement requirements. The resulting revised form, dated 2/22/09, has been piloted in several directly-operated and contract agencies over the past several months to ensure it fulfills its purpose and is as user friendly as possible.

PURPOSE OF THE CLIENT CARE COORDINATION PLAN

The Client Care/Coordination Plan (CCCP) is intended to guide client care and allow those working with a client to see a comprehensive record of goals, interventions, and services provided to an individual client. The Client Care/Coordination Plan also assists service delivery staff with the task of establishing sound markers of progress for a client and making clinical decisions regarding care.

The CCCP is a key document in completing the "Clinical Loop" which starts with the completion of the Initial Assessment, moves to the CCCP, and then to the Progress Notes. The CCCP documents all non-emergent services with appropriate goals/objectives and interventions which can be linked back to the symptoms, behaviors, and impairments documented in the Initial Assessment. All clinical interventions must be included in the progress notes and must be consistent with the client's goals/desired results identified in the CCCP.

Should it arise that services provided to a client are not consistent with the CCCP, the clinician or other appropriate staff should update the CCCP accordingly to ensure all services provided to a client are covered. It is important to remember that a client's CCCP should be updated and reviewed as clinically necessary based on the client's progress, ability to reach his/her goals, and readiness to change.

DO YOU KNOW THE ANSWERS TO THESE QUESTIONS?

1. Is it acceptable practice to have a DMH client sign a blanket Authorization for Request or Use/ Disclosure of Protected Health Information (PHI) to keep in their clinical record in the event it is needed at a later date?
2. A 19-year old client is a qualified dependent on a parent's health plan. If the parent calls for information about why their child was at the mental health facility, can the clinic release any information?

Answers on the next page

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Key Revisions to the CCCP:

- Client's strengths
- Removed duplicative items critical to reimbursement but which can be found in the Assessment or elsewhere in the Clinical Record such as:
  1. Barriers to reaching goals
  2. Presenting problems/symptoms
  3. Functional impairments
  4. Cultural/linguistic presenting problems
  5. Client's strengths
  6. Outcomes of family involvement
  7. Payer information
  8. Program/provider completing assessment
- Switched Mental Health Services (MHS) review period from Six Month to Annual
- Switched from Landscape to Portrait
- Inserted clarifying descriptions of signature requirements and who is eligible to sign for which types of services
- Separated out Coordination of Care onto a new page for ease of faxing and transferring information

Key Points Regarding the Revised CCCP: (see CCCP Instructions for a detailed list of guidelines and instructions)

- There are 3 basic pages and 2 addendum pages to the CCCP:
  1. Client Care Page and an addendum page
  2. Signature Page and an addendum page
  3. Coordination Page
- Client Care and Signature Pages must be completed by each program providing services to the client
- All non-emergent, direct services provided to a client should be listed on the Coordination Page, whether or not they are Medi-Cal reimbursable
- Any staff can write a goal/objective and intervention on the Client Care Page as long as it has the appropriate signature
- The CCCP should be filed in the client's chart with the most recent version on top in Section 3 "Assessment and Plans" (Contract Providers may file it in accord with their chart order.)

Implementing the revised CCCP:

The revised, form-fillable, CCCP is available on the DMH internet as of the date of this Bulletin. However, it is not expected to be implemented until training on the CCCP/SFPR has been received. Trainings are being held in each Service Area during the months of March and April. See the attached list of CCCP/SFPR trainings by Service Area and contact your Service Area QIC Liaison for training registration. It is expected that all Directly-Operated and Contract agencies will be using the revised CCCP for all new clients by the end of April, at which point the old CCCP will be removed from the DMH Internet. For existing clients, the current CCCP and its associated procedures may remain in effect until the next annual review period at which time the revised CCCP and procedures must be put into place.

For new client's, all Mental Health Services (MHS) will begin with an annual review period. For existing clients, the annual review period for MHS will not take effect until the client's next annual review. For example, if an existing client's MHS goals/objectives are up for a six-month review in May, the goals/objectives will still need to be reviewed in May. In November when the MHS goals/objectives are due for the annual review, the goals/objectives will switch over to the new annual review period and are not required to be reviewed/updated until the following November.

For further information regarding the revised CCCP, please see the revised pages of the Organizational Provider's Manual detailed CCCP Instructions and Frequently Asked Questions on the DMH Internet under Provider Tools. Questions should be directed to Service Area Liaisons who will forward them to QA as needed.

c: Executive Leadership Team, District Chiefs, Program Heads, Provider Record Keepers, ACHSA, RMD

I KNOW THE ANSWERS TO THOSE QUESTIONS!

1. No, the Privacy Rule requires a valid Authorization to contain "the name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested disclosure," at the time the client signs the Authorization.
2. No, since the age of majority is 18 in California, this client is an adult. Although his/her parent's plan provides coverage, the parent does not have the right to access his/her PHI without written authorization from the client.

CLIENT CARE COORDINATION PLAN

Annual Cycle Month: **(Due prior to the 1st day of the Month)**

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

Client Long Term Goals: (use client direct quote)

Short-term Goals / Objectives: Must be **SMART**: **S**pecific, **M**easurable/Quantifiable, **A**ttainable within this year, **R**ealistic, and **T**ime-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

Objective # 1 Effective Date: _____

Clinical Interventions: Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration (specify if time frame is less than 1 yr).

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other _____

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Outcomes: To be completed either when the objective is obtained or prior to the beginning of the next cycle month. If not met, please specify what was or was not met and adjust objective accordingly.

Initials: Date:

Short-term Goals / Objectives:

Objective # 2 Effective Date: _____

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other _____

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Outcomes:

Initials: Date:

Additional Client Contacts/Relationships: Refer to the "MH 525: Contact Information" form.	**Interpretation**
☐ DCFS ☐ Probation ☐ DPSS ☐ Health ☐ Outside Meds ☐ Regional Center ☐ Substance Abuse/12 Step ☐ Consumer Run/NAMI ☐ Education/AB 3632 ☐ Other _____	Prefer a language other than English: ☐ Yes ☐ No This plan was interpreted: ☐ Yes ☐ No Language: _____

*MHS includes therapy/rehab (individual, family, or group), psychological testing, collateral and team conference/consultation services.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

CLIENT CARE COORDINATION PLAN

- Signator or Co-Signator must be consistent with Scope of Practice.
- Signatures must be obtained when objectives are created (both initial and additional) and at each review period.
- One signature block can be used for multiple objectives created on the same day if the objectives are within the scope of the signator.

Objective Number(s) X&Y	Unlicensed Staff/Title	Used if Staff does not hold one of the licenses or registrations below. Second signature required.
	PhD/PsyD, LCSW, MFT, RN, CNS	**Required for all Objectives without MD/DO signature.** Includes licensed or registered and waivered PhD/PsyD, licensed or registered/waivered LCSW & MFT, Licensed RN, Certified CNS.
	MD/DO, NP	**MD/DO Required for Medicare Clients/Private Insurance.** MD/DO or NP required for Medication Support goals.
	Client*	Document reason for lack of signature below. Signature should be obtained as soon as possible with regular updates in Progress Notes until obtained.
	Other*	Parent, Authorized Caregiver, Guardian, Conservator, or Personal Representative for treatment.

Objective Number(s) ______	Unlicensed Staff/Title		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client*		Date:
	Other*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

Objective Number(s) ______	Unlicensed Staff/Title		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client*		Date:
	Other*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

Objective Number(s) ______	Unlicensed Staff/Title		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client*		Date:
	Other*		Date:

Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

*The signature of the individual signing the Consent for Services is required. If unavailable, the signature of the caregiver may be obtained instead.

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Agency: **Provider #:**

Los Angeles County – Department of Mental Health

Signature Page of the CLIENT CARE/COORDINATION PLAN

CLIENT CARE COORDINATION PLAN

Initial Assessment/Annual Assessment Update Completed on: _____

1 Week	30 Days	60 Days	3 Months	6 Months	Annual
☐ Crisis Residential	☐ Transitional Residential	☐ Long-Term Residential	☐ CalWORKS ☐ Day Treatment Intensive (DTI) ☐ TBS	☐ Day Rehab	☐ Mental Health Services (MHS) ☐ Medication Support (MSS) ☐ Targeted Case Management (TCM)

Objectives must be reviewed, updated, and recorded on the Signature and Coordination Pages prior to the first day of the cycle month. DR and DTI goals do not have to be on the Client Care and Signature pages but must be listed on the Coordination Page.

Cycle Months:	☐ January	☐ February	☐ March	☐ April	☐ May	☐ June
	☐ July	☐ August	☐ September	☐ October	☐ November	☐ December

Single Fixed Point of Responsibility (SFPR) Contact Information	
SFPR:	**Phone Number:**
Provider/Agency:	**Fax Number:**

Provider Name / Number	Contact Person / Team	Type of Service*	Start Date (Mo/Day/Yr)	End Date (Mo/Day/Yr)	Discharge or Transfer Date (Mo/Day/Yr)	SFPR's** Approval (Date & Initial)	Verbal Approval (Date & Initial)

* Services listed should include **MHS, TCM, Med Support, TBS, Day Treatment Intensive, or Day Rehab.**
** For DT and DR note the Authorization Unit's approval date.

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Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

Coordination Page of the CLIENT CARE/COORDINATION PLAN

MH 636A
Revised 2/22/09

CLIENT CARE COORDINATION PLAN

Addendum Page 1A

Short-term Goals / Objectives:

Objective # Effective Date: ________

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other __________________

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Outcomes:

Initials: _______ Date: _______

Short-term Goals / Objectives:

Objective # Effective Date: ________

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other __________________

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Outcomes:

Initials: _______ Date: _______

Short-term Goals / Objectives:

Objective # Effective Date: ________

Clinical Interventions:

Type of Service: ☐ MHS* ☐ TCM ☐ Med Sup ☐ Crisis Res ☐ Trans Res ☐ Long-Term Res ☐ Calworks ☐ TBS ☐ Other __________________

Client Involvement	**Family Involvement:** ☐ Biological ☐ Other (If other, please specify below)
Client agrees to participate by:	Family is available ☐ Yes ☐ No Client consents to family participation? ☐ Yes ☐ No ☐ N/A Family agrees to participate? ☐ Yes ☐ No (If yes, please specify)

Outcomes:

Initials: _______ Date: ________

*MHS includes therapy/rehab (individual, family, or group), psychological testing, collateral and team conference/consultation services.

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Client Care Addendum of the CLIENT CARE/COORDINATION PLAN

CLIENT CARE COORDINATION PLAN

Objective Number(s) ______	Unlicensed Staff/Title*		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client		Date:
	Other		Date:
Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:			
If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.			

Objective Number(s) ______	Unlicensed Staff/Title*		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client		Date:
	Other		Date:
Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:			
If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.			

Objective Number(s) ______	Unlicensed Staff/Title*		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client		Date:
	Other		Date:
Client was offered a copy of this objective: ☐ Accepted ☐ Declined Staff Initials: Date:			
If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.			

* Requires Co-Signature

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CCCP/SFPR Training Schedule

SPA	Training Date & Time	Training Location	Notes
1	March 24th (Tues.), 2009 9:00am - Noon	Mental Health of America 506 West Jackman Lancaster, CA 93534	Contact: Marjorie Borjon Phone: 616.223.3800
2	March 16th (Mon.), 2009 9:00am - Noon	San Fernando Valley Comm. Mental Health Center 6842 Van Nuys Blvd., 6th Floor Van Nuys, CA. 91405	Contact: Kimber Salvaggio Phone: 818.610.6704
3	April 15th (Wed.), 2009 9:30am – 12:30pm	Enki Youth & Family Services 3208 Rosemead Blvd., Suite #100 El Monte, CA. 91731	Contact: Bertrand Levesque Phone: 213.739.5442
4	March 30th (Mon.), 2009 1:00 – 4:00pm	LAC-DMH 550 South Vermont Avenue, 2nd Floor Conference Rm. Los Angeles, CA. 90020	Contact: Anahid Assatourian Phone: 213.738.3423
5	March 10th (Tues.), 2009 9:00am - Noon	Didi Hirsch Community Mental Health Center 4760 South Sepulveda Blvd. Culver City, CA. 90230	Contact: Monika Johnson Phone: 310.268.2561
6	April 1st (Wed.), 2009 9:00am - Noon	Kedren Community Mental Health Center 4211 South Avalon Blvd. Los Angeles, CA. 90011	Contact: Kimberly Spears Phone: 323.298.3675
7	March 23rd (Mon.), 2009 1:00 – 4:00pm	Enki Youth & Family Services – Margarita Mendez 1000 Goodrich Blvd. Commerce, CA. 90022	Contact: Lupe Ayala
8	March 11th (Wed.), 2009 9:00am - Noon	Long Beach Memorial Hospital – Van Dyke Theatre 2801 Atlantic Avenue Long Beach, CA. 90806	Contact: Ann Lee Phone: 562-435-3027
Countywide	March 30th (Mon.), 2009 9:00 – 12:00pm	LAC-DMH 550 South Vermont Avenue, 2nd Floor Conference Rm. Los Angeles, CA. 90020	Contact: Terra Mulcahy Phone: 213-739-2396
TBS	To Be Determined		