Care Plan within a Service Note Checklist

☐ **Care Plans may include/combine more than one service, as long as those services are clinically covered and within the scope of practice of that staff.**

- Example: If a provider is going to provide both FSP and TCM services, then those can be combined into one Care Plan because those are both clinically covered and within the scope of practice of that staff. There would not need to be multiple plans for clinical services.
- The Certified Peer Plans would be separate as that would be a separate scope of practice and expertise needed.
- The Housing Plans would be separate as well because there are components of that plan that are unique in relation to frequency, amount, and sustainability.

MH Services that require a Care Plan

- ☐ Targeted Case Management/Case Management
- ☐ Peer Support Services
- ☐ Therapeutic Behavioral Services (TBS)
- ☐ Intensive Care Coordination (ICC)
  - This may include the plan to provide other services as part of that ICC such as, IHBS or TFC.
- ☐ Short Term Residential Therapeutic Programs (STRTP)
- ☐ Social Rehabilitation Programs (including Crisis Residential)
- ☐ MHSA FSP (ISSP)

❖ In addition, providers that provide these specific services would also follow any relevant regulatory requirements associated with that service per BHIN# 23-068, Enclosure 1A. Please refer to BHIN# 23-068, Enclosure 1A for specific details of programs, services and facility types that require a Care Plan. For ECM Care Plan requirements, please refer to corresponding P&P ECM-02: https://dhs.saccounty.gov/BHS/Documents/BHS-Policies-and-Procedures/PP-BHS-ECM-02-Provider-Service-Provisions.pdf

Components that may be in the Care Plan (within the Service Note)

☐ **Staff must add: Type(s) of Care Plan, Staff First and Last Name, Classification**; Date Updated.

- *Example: Targeted Case Management Care Plan (Helpful Clinician, LMFT; 7/1/2023)*

☐ **Goals**: Specify the goals, treatment, service activities/interventions, and assistance to address the agreed upon objectives of the plan and the medical, social, educational, and other services needed by the member.

☐ **Interventions**: Include activities/interventions such as ensuring the active participation of the member and working with the member (or the member's authorized health care decision maker) and others to develop those goals.

☐ **Course of Action**: Identify a course of action to respond to the assessed needs of the member.

(This can be step by step activities or phases of treatment to get the member prepared in making active progress towards the goal.)

☐ **Transition Plan:** Include development of a transition plan when a member has achieved the goals of the care plan.

- **For more information please refer to** QM-10-27 Problem List, Treatment, and Care Planning – MHP and DMC-ODS **or email QMInformation@saccounty.gov.**