Introduction

Mental Health Plan (MHP) Targeted Case Management / Case Management Care Plan

This document is intended as guidance for mental health staff who are providing Targeted Case Management (TCM) / Case Management (CM) services. Case management for mental health providers is called Targeted Case Management (TCM) and is the same service as Case Management (CM); TCM / CM are interchangeable.

All active TCM / CM services now require the creation of a **Care Plan** within the narrative of a progress note; TCM/CM services ***no longer*** require a Treatment Plan. The Care Plan is resolved when the goals of the Care Plan are achieved. The Avatar **Problem List** is a separate required document. Providing TCM/CM services should support resolution of problems on the Problem List. The Avatar Treatment Plan Form will not be used for TCM / CM services.

CalAIM implementation is dynamic; guidance regarding TCM/CM Care Plans will be updated if/when updated guidance is received by County BH QI Department. The Avatar progress note form will be updated to better reflect CalAIM documentation standards. Until that update, the current Avatar progress note form will be used. Guidance will be updated and released when the Avatar form is updated.

In the remainder of this document, Targeted Case Management (TCM) = Case Management (CM).

Note: Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) still require a Treatment Plan; guidance for ICC and IHBS treatment plans will be coming soon from the County QI Department.

Definition: Targeted Case Management (TCM) / Case Management (CM)

TCM/CM is:

- Assessing needs for any medical, educational, social, prevocational, vocational, rehabilitative, or other community services
- Developing and revising an individualized Care Plan
- Referring / linking to services to help address needs and resolve problems, including communication and coordination with needed community service providers
- Monitoring service delivery to ensure access to services
- Monitoring individual progress, including following up and coordinating with others to ensure the Care Plan is effectively implemented and adequately addressing the person's needs

General Care Plan Guidance

TCM services require a Care Plan in the narrative of a progress note; a TCM Care Plan is now required when providing TCM services. The Care Plan will be based on information collected through the

assessment and revised periodically. TCM services should be provided throughout the course of treatment whenever clinically indicated. TCM services are no longer authorized on the Avatar Treatment Plan form.

When to document a Care Plan within a new progress note:

- Targeted Case Management (TCM) services are first initiated (subsequent TCM notes do not require a Care Plan).
- The need / focus of TCM changes, and/or new needs / problems are identified that indicate TCM services.

How to develop the Care Plan:

- Document the Care Plan in the narrative of an Avatar General Purpose Progress Note form
- Include active participation of the person in care
- Base the Care Plan on the identified needs and Problem List of the person in care that would benefit or be resolved by receiving TCM services
- The signature of the person being served / client is ***not*** required
- Any provider (licensed, license eligible and paraprofessional) operating within their scope of practice can provide and bill for TCM (Except FQ Therapists)

What to include in the Care Plan:

- Goals, treatment, service activities and assistance to address the objectives of the plan
  - What will be achieved by TCM service (what is the goal)?
  - A statement that case management treatment / services will be provided and the purpose of the TCM services
  - What activities or assistance will you use (linkage, referral, monitoring and placement related activity) to address medical, social, educational & other resource needs?
- How did the person in care participate in Care Plan development?
- Description of a transition plan that explains how TCM will end when the person in care has achieved the goals of the Care Plan

TCM / CM Progress Note Service Codes

- The service code when ***providing*** TCM is Case Management: M401; if you create the TCM Care Plan while providing TCM service, the service code is Case Management: M401
- The service code when the service is ***solely creating*** the Care Plan is Plan Development: M432 (used when ***not*** doing a case management service activity)

TCM / CM Progress Note Content

DIRP format is not required. We are still working under the current restraints of the Avatar progress note form until it is updated. Until that update, the current Avatar progress note form will be used.

Template content:

Presentation: Not required, however Avatar will force you to write something.
You may write a brief client presentation here or write, "see intervention section below."

Intervention (Narrative Description of Service): This section specifies the goals, treatment, service activities and assistance to address the negotiated objectives of the plan, as well as the medical, social, educational, and other services needed by the person in care.
Include how the person in care was included and participated.

Response: Not required, however Avatar will force you to write something.
You may write a brief client response here or write, "see intervention section above."

Referrals to Community Services: Not required.
You may include brief referrals provided.

Follow up Care/ Discharge Summary:
Include next steps, information regarding collaboration with the person in care and others and a transition plan for when the person in care has achieved the goals of the care plan.

TCM / CM Progress Note Examples

Example of TCM <u>Care Plan Creation</u> Progress Note (TCM is beginning):

Billable Service Code: Plan Development M432

Presentation:
See intervention section below.

Intervention (Narrative Description of Service):
Met with Susan to participate in the Case Management Care Planning process. Susan reported that a current important goal for her is to find affordable housing after Adult Residential program as she was homeless before beginning adult residential treatment. Susan is interested in going to subsidized housing programs. TCM will be provided to provide linkage to housing support services for Susan. This writer will coordinate with housing and rental support services in the community to help Susan with this goal.

Response:
See intervention section above.

Referrals to Community Services:
Referred to Housing Support Team and Section 8 Housing.

Follow up Care/ Discharge Summary:
Writer will provide case management activities to help Susan connect with community resources and access applications to housing programs for lower level of care. Writer will continue to monitor current placement. Goal will be achieved once Susan is connected and has transitioned to stable housing.

Example of TCM Progress Note:

Billable Service Code: Case Management M401

Presentation:
See intervention section below.

Intervention (Narrative Description of Service):
This staff provided the following intervention to address the client's inability to manage emotions due to their anxiety; client reported their anxiety to be high and that they would like to attend a group that focuses on anxiety and depression. This staff contacted Group Intervention Center and spoke with an intake counselor to obtain information about the appropriateness of their Anxiety Support Program to meet client's needs.

Response:
See intervention section above.

Referrals to Community Services:
Referred to Group Intervention Center Anxiety Support Group.

Follow up Care/ Discharge Summary:
Staff completed the referral process by summarizing client's anxiety symptoms and highlighting strengths, including supportive family members. Anxiety Support Program indicated client seemed appropriate for their program group and provided staff with information on next steps. This staff will contact client to discuss eligibility for the program and assist client in preparing to attend this support group.

Resources

- CalMHSA Documentation Guides: HERE
- Santa Cruz County CalAIM Information Page: HERE
- DHCS Behavioral Health Information Notice 22-019: Documentation Requirements: HERE