## Introduction

**Mental Health Plan (MHP) Progress Notes**

This document provides interim guidance for all **mental health** staff regarding writing progress notes that meet CalAIM standards. We are still working under the constraints of the ***current*** Avatar progress note form until it is updated. Until that update, the current Avatar progress note form will be used. Information regarding the ***updated*** Avatar progress note form can be found later in this guide. The ***updated*** progress note form is accessible now in Avatar **UAT**. Per request of supervisors, BH will not transition to use of the ***updated*** progress note form until ***September 19, 2022,*** to allow for staff time to review and learn about the new form prior to the form going live. Staff will be notified when the ***updated*** Avatar progress note form is active in Avatar LIVE.

Progress notes are a communication tool used as a basis for planning client care and treatment among practitioners and across programs. A focus of CalAIM is to simplify progress note documentation to ***decrease*** the time providers spend documenting so they can focus more time on working with the person in care. Progress notes are to be lean; a progress note should provide an accurate picture of the person's condition, include the treatment / interventions provided, and their response to care at the time the service was provided.

Progress notes are ***no longer*** required to be in DIRP (data, response, intervention, plan) format. Services are to be documented in the narrative of the progress note and should reflect what is clinically indicated for the person in care.

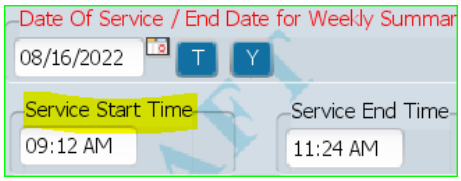
## Progress Note Due Dates

The purpose of the progress note is to communicate information quickly, and to describe treatment provided. In order to facilitate prompt communication, CalAIM standard for ***routine*** outpatient and residential services is completion of the progress note within three (3) business days. State oversight has defined "**business day**" as any day a provider is open and provides services. The date of service = day 0. Routine outpatient and residential progress notes are to be completed and finalized within ***3 business days*** of the date of service. Progress note timeliness requirements are for the direct service provider who write the progress note; for some providers, co-signatures may still be required.

Examples:

- Programs Open Monday through Friday
  - Date of service = Monday, note must be finalized by end of day (EOD) Thursday
  - Date of service = Friday, note must be finalized by end of day (EOD) Wednesday
- Programs Open 7 days / week
  - Date of service = Monday, note must be finalized by end of day (EOD) Thursday
  - Date of service = Saturday, note must be finalized by end of day (EOD) Tuesday

***Crisis service notes*** are to be completed and finalized within ***24 hours*** of the start of the crisis service provided. Crisis service progress notes require the service start time and service end time to be included in the progress note.




The 24-hour "clock" begins at the service start time and ends when the note is finalized by the provider. **If a progress note is late, the delay should be an explained within the progress note.**

## Group Progress Note Guidance

As of July 1, 2022, one group practitioner may document group facilitation by multiple practitioners. For groups facilitated by multiple practitioners, a single progress note signed by one of the practitioners shall be used to document the group service provided. Information about the specific involvement and specific amount of time of involvement of each practitioner in the group activity must be documented.

HOWEVER, the current Avatar group progress note form is not set up to bill for two facilitators' time in one group progress note. The avatar group progress note form will be updated to support this shift in practice. Until the group progress note form is updated in Avatar, please continue to have group facilitators document their own group progress notes for co-facilitation of a group to ensure both group facilitators' time is accounted for. QI will issue updated guidance around documenting more than one group facilitator's time and involvement in one group progress note once the avatar group progress note form has been updated.

## General Progress Note Guidance & Tips

For detailed information regarding progress notes and progress note completion, please review the CalMHSA Progress Note training module and the CalMHSA Documentation Guides: HERE

Progress note Tips:

- Clear, concise, and easily understandable (avoid jargon and abbreviations)
- When possible, include active participation and quotes from the person in care
- Focus on interventions that addressed the person in care's behavioral health needs (symptoms, conditions, diagnosis, risk factors)
- Include how problems on Problem List were addressed; include updates to the Problem List
- Include next steps for provider and person in care
- The person in care has legal privilege to their medical record and may review the medical record documentation; notes should be understandable so the client can recognize the treatment described
- May document co-occurring (mental health and substance use disorder) treatment with clinically appropriate services for a mental health condition in the presence of a co-occurring substance use disorder; services delivered shall be within the practitioner's scope of competence

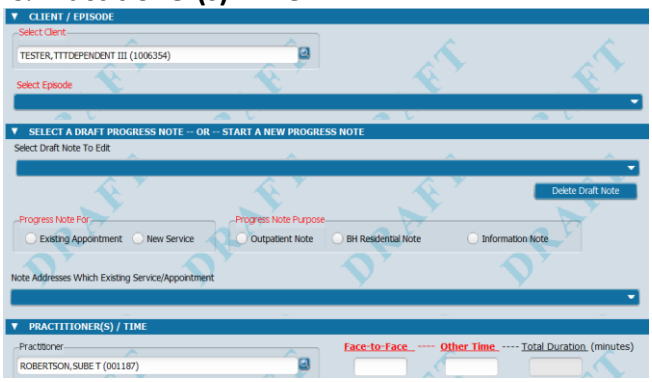
- If one practitioner provides multiple services of the **same service type** (ex: assessment, case management, collateral) to the same person on the same day, consider writing one note for a cumulative duration of time rather than separate notes (all services must have been provided by the same staff person).
- Specialty Mental Health providers ***are not limited*** to one service per day (except FQHC)

## How To Write a Note In The Current Avatar Progress Note Form (Now until 9/19/22)

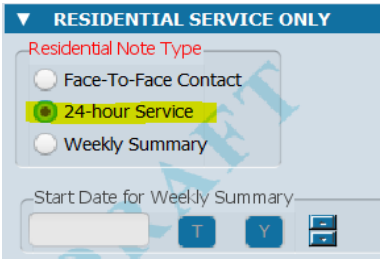
**See "Future Avatar Progress Note" section later in this document for guidance on the updated Avatar progress note form; the updated progress note form is expected to go LIVE on September 19, 2022**

### ***Current*** Avatar Progress Note Form Completion:

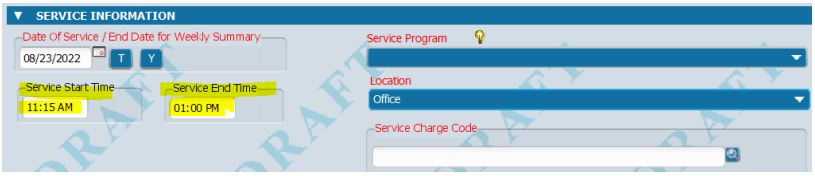
**For Client / Episode** & **Select Draft Progress Note** & **Practitioner(s) Time:**
All Outpatient: No change
Residential: No change




**Residential Services Only Section:**
All Outpatient: not applicable
***Residential: Select 24-hour Service***

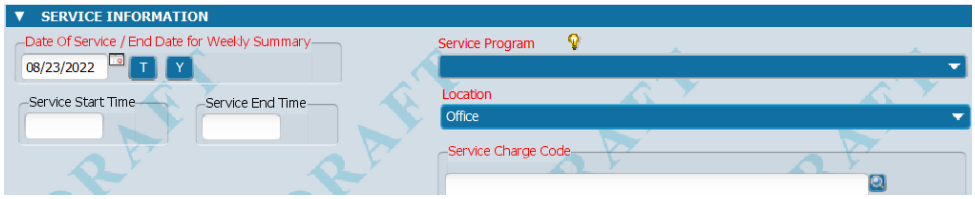



**For Service Information Section:**
**Crisis** Service:
The 24-hour "clock" begins at the service start time and ends when the note is finalized by the provider
Complete:
Date of Service,
Service Start Time, Service End Time
Service Program, Location
Service Charge Code



**Outpatient** (Non-Crisis):
Complete:

- Date of Service
- Service Program
- Location
- Service Charge Code

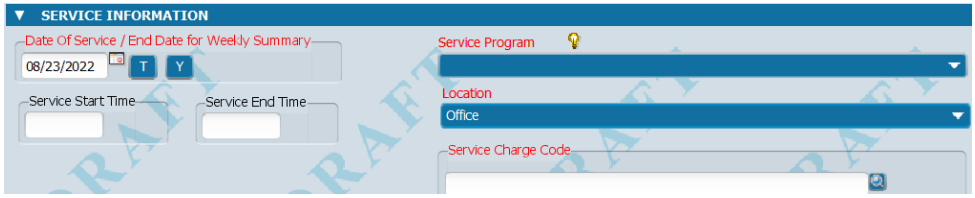



**Service Information Section:**

**Residential, TELOS**

Complete:

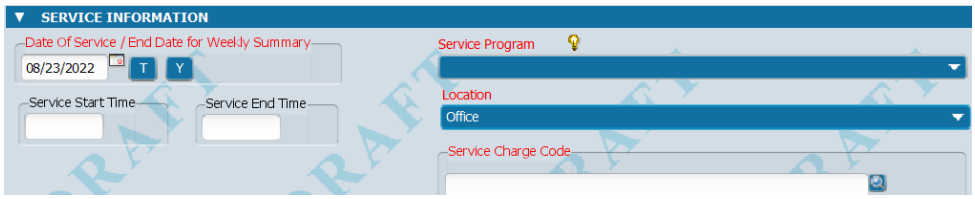
- Date of Service
- Service Program
- Location
- Service Charge Code: **M141** crisis residential




**Residential, EDC / Casa Pacific**

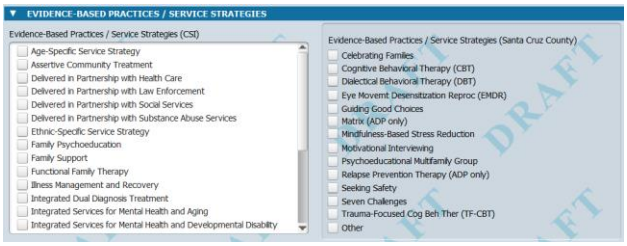
Complete:

- Date of Service
- Service Program
- Location
- Service Charge Code: **M180 non billable Residential Weekly Summary**



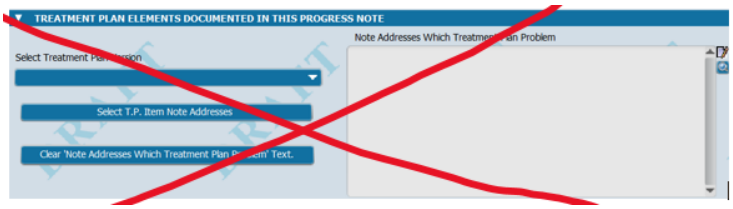

**NOTE: See below for CHANGES to Service Charge Code for EDC & Casa Pacific**

**Evidence Based Practices / Services Strategies Section:**
Outpatient & Residential:
Not required but encouraged; check with your supervisor

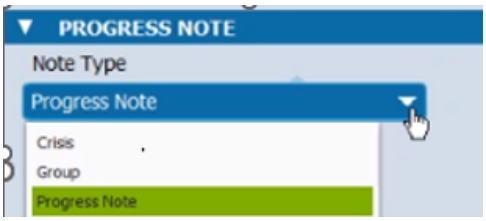



**Language Section:**
All Outpatient: No change
Residential: No change

**Treatment plan Elements Documented In This Progress Note Section:**
Outpatient & Residential:
No longer included unless you have provided a service that requires a treatment plan (ICC, IHBS, TBS, STRTP).
Treatment plan information will no longer be pulled into the note for *most* services.
Targeted Case Management (TCM) requires a **Care Plan** documented in the narrative of a progress note; Care Plan elements cannot be pulled into the progress note template.




**Note Type Section:**
All Outpatient: No change
Residential: No change




**Progress Note Content:**

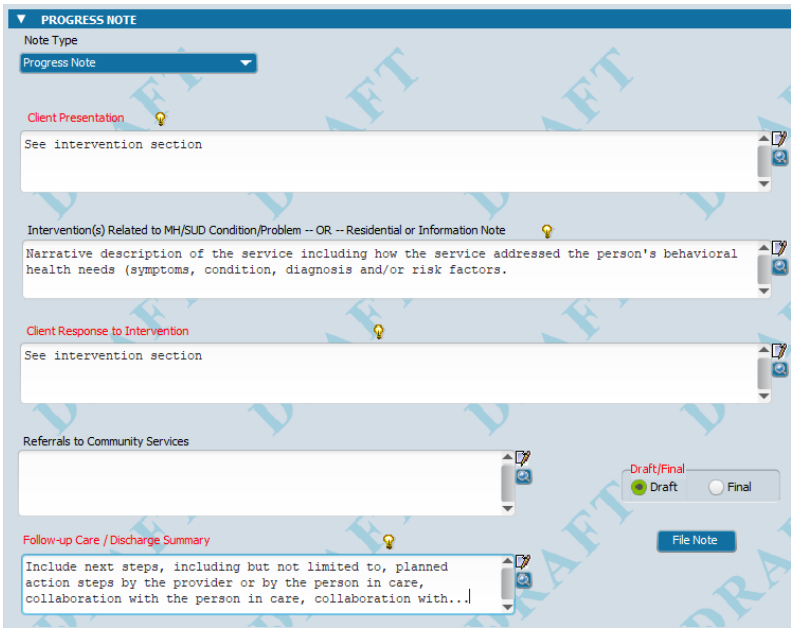
**Presentation:** Not required, however Avatar will force you to write something.
You may write a brief client presentation here or write, "see intervention section."

**Intervention (Narrative Description of Service)**:
Narrative description of the service, including how the service addressed the person's behavioral health (MH / SUD) need (symptoms, condition, diagnosis and/or risk factors) and the purpose of the service. Describe interventions utilized and how the person in care was included and participated. Include relevant description of the presentation of the person in care. Include progress towards problems on problem list if applicable.

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

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

**Follow up Care/ Discharge Summary**:
Include next steps, including but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other providers and any update to the problem list as appropriate.




NEW !!

## EDC & Casa Pacific Residential Service Code Changes, effective September 19, 2022

**Beginning on September 19, 2022, EDC & Casa Pacific Residential programs will discontinue the use of M180 non-billable code and instead will utilize the Service Charge Code M165 Adult Residential when documenting the daily residential progress note.**

**If clinician is unclear which service code to utilize, consult with your clinical supervisor for guidance.**

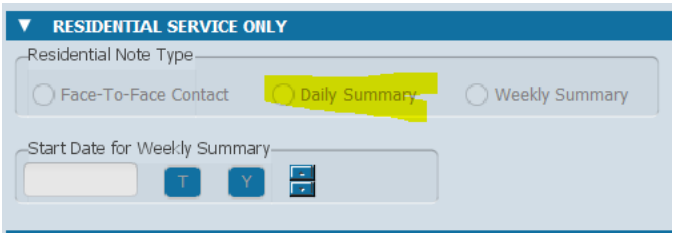
## Updated Avatar Progress Note Form (Live September 19, 2022)

**NOTES:**
**Progress note fields that are no longer required (client presentation & client response) must be kept in the updated form because if they are removed, we can no longer see them in past progress notes. We need to keep this historical documentation. Fields that are no longer required will be optional (no longer red).**

**In the Updated Progress Note form, *unless noted below*, fields will not change.**
**These fields will have the following CHANGES:**

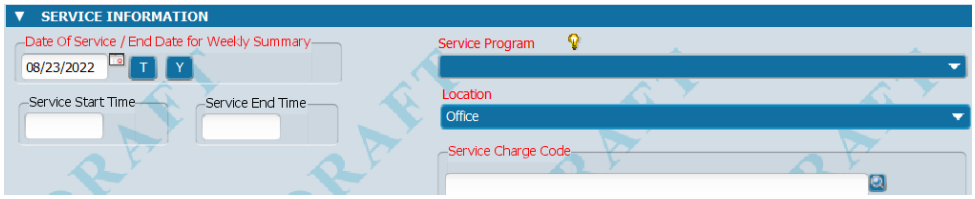
**Residential Services Only Section:**
Outpatient: Not applicable

**CHANGE: Residential programs- Select Daily Summary button**



**Service Information Section:**
Residential (EDC / Casa Pacific):

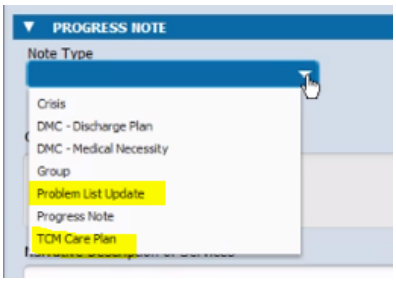
**CHANGE: Use code M165 adult residential**




**Note Type Section:**

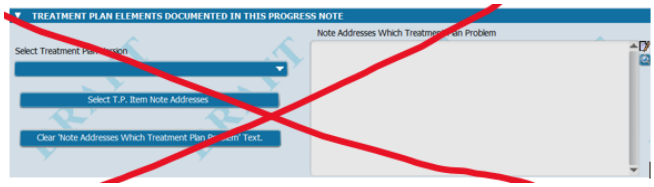
**CHANGE: Additional Note Types added:**

- **Problem List Update**
- **TCM Care Plan**



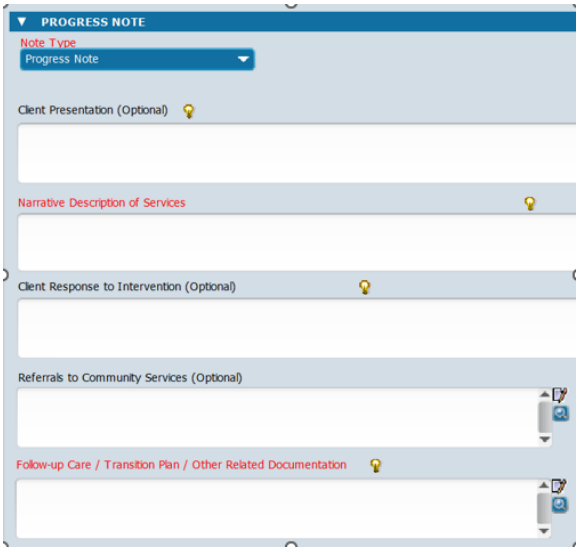

**Treatment plan Elements Documented in This Progress Note Section:**

Outpatient & Residential:
No longer included unless you have provided a service that requires a treatment plan (ICC, IHBS, TBS, STRTP). Treatment plan information will no longer be pulled into the note for most services.




**Progress Note Content Section:**
All:

**CHANGE:**
**Required (red) fields updated: ONLY Narrative & Follow-Up Care will be required fields; other fields are optional and available for use as indicated**



## Progress Note Examples

**Individual Rehabilitation Note**:

**Billable Service Code: M445 Individual Rehabilitation Counseling**
**Intervention:**
Enrique said he needed to "find a place to live". Enrique has not been able to remain in stable housing as he forgets to take his medication, uses substances, and then experiences mental health deterioration which has caused him to lose his housing in the past. Counselor practiced living skills with Enrique such as reminding him of his medication schedule, teaching steps needed to cleani his personal space, and assistance with budgeting. Counselor reviewed Enrique's coping skills and he said he has been "taking walks" daily to help him when he feels overwhelmed.

**Follow up care/discharge summary:** Counselor will call Enrique's housing coordinator to get an update on the status of the housing application as well as review the progress Enrique is making towards his goal of finding housing. Enrique will work on increasing his independence with living skills to support his success towards meeting his goal of finding housing.

**Case Management Note**:

**Billable Service Code: M401 Case Management**

**Intervention**: Angela continues to be disorganized due to voice hearing. Staff called Angela's medication provider to schedule Angela's next Psychiatry appointment as her disorganization was a barrier to her scheduling this appointment herself. Requested Angela be referred to in-home medication support services to meet Angela's need for increased support in taking her medications consistently. Referred Angela to a community group program focused on coping skills for voice hearing and shared with the counselor there Angela's struggles with symptoms of voice hearing making it difficult for her to do day-to day tasks; also shared that Angela's mother was a big support for her.

**Follow up care/discharge summary:** Counselor will call Angela's psychiatrist to confirm upcoming appointment as well as call the in-home medication support team to follow up on this referral and next steps. Staff will update Angela's mother on referrals made.

**Daily Residential Progress Note Example:**

**Intervention**: Isabella slept well and complied with morning and bedtime medication. Appetite was normal & hygiene was good. Staff provided individual rehabilitation counseling activities to assist Isabella with her intrusive thoughts and visualizations of the devil following her around which cause her to socially isolate, and not take care of herself. Staff practiced mindfulness stress reduction with Isabella by encouraging deep breathing exercises, body relaxation, and yoga. Staff provided empathetic listening and coached Isabella with reality- based testing. Isabella stated that she is, "feeling a bit anxious but the breathing helped." Isabella met with Nurse Practitioner this afternoon to discuss her medications. Isabella attended seeking safety, living skills, and symptom management educational groups.

**Follow up care/discharge summary:** Staff called Isabella's coordinator to ask that her coordinator meet with her to provide additional support to help her be successful in the residential environment. Staff spoke with Isabella's psychiatrist to share concerns regarding Isabella's symptoms. Isabella and staff will continue to work on increasing use of mindfulness coping skills.

**Additional sample progress notes can be found in the CalMHSA Documentation Guides.**

## Resources

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