COUNTY OF SAN LUIS OBISPO
HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT
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Mental Health Documentation Guidelines

FY 2023-2024

Report suspected inappropriate documentation, coding, or billing practices:

Confidential Compliance Hotline
855-326-9623

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OVERVIEW

SLO County Behavioral Health Department Quality Support Team produces and periodically updates the *Documentation Guidelines* to serve as the official reference for all outpatient clinical documentation. This manual serves as a guidance document to promote excellent, accurate and timely documentation of the services we provide to our community. We strive to provide high quality care to our clients, and accurate documentation is a crucial step in the process of delivering excellent care.

The *Documentation Guidelines* defines key concepts, explains documentation requirements, and provides examples of how to document various types of specialty mental health services. Look here first whenever you need an answer to a documentation question. Inevitably, you will have questions that this manual does not answer – when that happens, consult your Program Supervisor or Quality Support Team staff. We are available to answer questions about documentation and to provide training.

This *Documentation Guidelines* includes information from the following sources: California Code of Regulations (Title 9), the California Department of Health Care Service's (DHCS) Information Notices and Triennial Audit Protocol, the County of San Luis Obispo Behavioral Health Department's (SLOBHD) policies & procedures, and the contract between DHCS and SLOBHD. References to additional information (regulations, Policies, Practice Guidelines, etc.) are included for more detail.

✧ Definition of Key Terms ✧

Child and Adolescent Needs and Strengths (CANS): We use the CANS, copyrighted by the Praed Foundation, to support individual case planning and outcome measurement on an individual and system-wide basis.

Client: For outpatient treatment and voluntary inpatient treatment, a client is an individual who gives informed consent for treatment (see definition below) and has an expectation of privacy. Legally Responsible Persons may consent on behalf of minors and LPS conservatees. Any person admitted to the psychiatric health facility (PHF) is a Mental Health client, whether or not the admission is voluntary. We assign a medical record number to a client in SmartCare, our electronic health record (EHR).

Consent for Treatment: Prior to beginning outpatient and voluntary inpatient services, every client and/or Legally Responsible Person must make an informed decision about the risks and benefits of treatment (including no treatment). Signature of the client (aged 12 or older) on the Consent for Treatment documents that the individual agrees to participate in treatment. A Legally Responsible Person must sign on behalf of all minor clients who are not consenting for

treatment on their own and for all LPS conservatees. Consent for treatment obtained for voluntary treatment on the PHF is valid for outpatient treatment. The form does not need to new signature, but the clinician completing an outpatient assessment must always review the risks and benefits of treatment with the client again to ensure that the client makes an informed decision about treatment. Consent for treatment is valid from the date of signature until treatment ends or until revoked by the client or Legally Responsible Person. For more information about signature requirements for minors and LPS conservatees, please refer to Appendix A.

Long-term client: Any individual who meets access criteria and has been or is expected to be a client for at least a year.

Service Time – In SmartCare, service time includes all modes of delivery including face-to-face, telephone (telehealth audio only), video conferencing (telehealth video + audio), and written. This is where staff should capture the total service time, which includes time spent completing screening and assessment documentation and time spent reviewing the client record.

Significant Support Person: A person who could have a significant role in the successful outcome of the treatment of the beneficiary (e.g., parents, legal guardian of a minor, legal representative of an adult, spouse, a person living in the same household).

Scope of Practice and Role Acronyms:

- **Licensed Mental Health Professional (LMHP)**
  DHCS Informational Notice 17-040 identifies a group of staff who may "direct" services. Direction may include, but is not limited to, providing services, acting as a team leader, providing clinical or functional supervision of service delivery, or approving Treatment Plans. LMHP staff who direct services must be a Physician, Psychologist, LCSW, LMFT, LPCC, RN, Certified Nurse Specialist, or Nurse Practitioner (NP).

  Staff in other disciplines or with other credentials provide Specialty Mental Health Services (SMHS) within their respective scopes of practice, "under the direction of" an LMHP, and as determined appropriate by SLOBHD. Examples of staff who provide services under the direction of an LMHP may include, but are not limited to LVN, PT, Physician's Assistant (PA), Pharmacist, Occupational Therapist (OT), Registered Associate, Trainee, Rehab Specialist, Case Manager, Worker/Worker Aide, Peer, and Health Navigator.

- **Staff who may render a diagnosis**: A slightly different list of staff disciplines may render a diagnosis. This list includes a Physician, Psychologist, LCSW, LMFT, LPCC, and NP. Consistent with State law and "under the direction of" a staff listed in this definition,

Registered Associates and Trainees in one of these disciplines may also render diagnoses.

- **Medically licensed staff**: Only the following staff are qualified to provide medication support or other services that require a medical license: Physician, Pharmacist, NP, PA, RN, LVN, and PT.

✧ Medical Necessity for Outpatient Specialty Mental Health Services (SMHS) ✧

Medical Necessity refers to appropriate, non-fraudulent medical services.

For Individuals 21 years of age and older a service is "medically necessary" when it is reasonable and necessary to protect life, to prevent a significant illness or significant disability, or to alleviate severe pain.

For Individuals under age 21 services are medically necessary if the service is needed to correct and ameliorate mental illness and conditions. Services do not need to be curative or completely restorative to ameliorate a mental health condition. A service is considered to ameliorate if it serves to sustain, support, improve, or make a mental health condition more tolerable.

✧ Access Criteria for Outpatient Specialty Mental Health Services (SMHS) ✧

Access Criteria is the criteria a beneficiary must meet in addition to the medical necessity criteria to receive services.

The criteria for an individual to access outpatient SMHS **shall not exclude** coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service in any of the following circumstances:

1. Services are provided prior to determining a diagnosis, including clinically appropriate services provided during the assessment process
2. The prevention, screening, assessment, and treatment or recovery service was not included on a treatment plan
3. The beneficiary has a co-occurring substance use disorder

Diagnosis Criteria
A mental health diagnosis is not a prerequisite for access to covered SMHS, however this does not eliminate the requirement for all Medi-Cal claims, including claims for SMHS, to include an approved ICD-10 diagnostic code. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to significant trauma, Z code diagnoses, such as Z03.89 "Encounter for observation for other suspected diseases and conditions ruled out," may be used.

<u>Access Criteria for individuals 21 years of age and older</u>
SMHS shall be offered for adult beneficiaries who meet both of the following criteria:

1. The beneficiary has **one or both** of the following:
   a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities
      AND/OR
   b. A reasonable probability of significant deterioration in an important area of life functioning

AND

2. The beneficiary's condition as described in item (1) above is due to **either of the following**:
   a. A diagnosed included mental health disorder
      OR
   b. A suspected mental disorder that has not yet been diagnosed

<u>Access Criteria for individuals under age 21</u>
SMHS shall be provided to youth beneficiaries who meet **either of the following** criteria:

1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness

OR

2. The beneficiary meets **both of the following** requirements in a) and b) below:
   a. The beneficiary has **at least one** of the following:
      i. A significant impairment
         AND/OR
      ii. A reasonable probability of significant deterioration in an important area of life functioning

AND/OR

iii. A reasonable probability of not progressing developmentally as appropriate

AND/OR

iv. A need for SMHS, regardless of presence of impairment, that are not included with the benefits that a Medi-Cal managed care plan is required to provide

AND

b. The beneficiary's condition as described in (2) above is due to **one of the following**:

i. A diagnosed included mental health disorder

OR

ii. A suspected mental health disorder that has not yet been diagnosed

AND/OR

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a LMHP

Our goal is to provide the right services in the right amount to the right clients to meet their needs.

✧ Specialty Mental Health Services ✧

AZ Service Code	SmartCare Service Code	Description	Disciplines
100 – Assessment	Assessment Contribution non-LPHA	Assessment work/services completed by non-clinical staff. Assessment means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health.	All Providers
	Assessment LPHA	Integrated biopsychosocial assessment, including history, mental status, and recommendations.	Licensed, Registered, Waivered Clinician
	Medication Support New Client – To be used for assessment services scheduled with prescribers for	Evaluation and management medication support services provided to new patients.	MD/DO/NP

	new clients		
	Review of Hospital Records	Review of records for psychiatric evaluation without direct patient contact.	MD/DO/NP/ Licensed, Registered, Waivered Clinician
203 – Crisis Intervention	Psychotherapy for Crisis	Urgent assessment and exploration of an individual in crisis. Includes mental status exam, therapy, mobilization of resources, and implementation of interventions to address the crisis. Client must be present for at least part of the service.	MD/DO/NP/ Licensed, Registered, Waivered Clinician
	Crisis Intervention Service / Mobile Crisis	A service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit.	All Providers
303-307 – MH MD E&M Office Visit	Consults for New and Established Patients	Medical decision making, provider sees a patient for an office or other outpatient consultation involving evaluation and management (E/M).	MD/DO/NP
	Medication Support Existing Client	Evaluation and management medications support services provided to established patients.	MD/DO/NP
	Medication Support New Client	Evaluation and management medication support services provided to new patients.	MD/DO/NP
	Medication Support Telephone	Evaluation & Management services provided by telephone.	MD/DO/NP
	Medication Injection	Psychiatric medication intramuscular and subcutaneous injections.	MD/DO/NP/RN
	Physician Consultation	Consultative physician inter-professional assessment	MD/DO

		(telephone/internet or electronic).	
	Psychotherapy with Patient with an EM Service	Psychotherapy services provided as part of an evaluation and management service.	MD/DO/NP
301 – Medication Support	Oral Medication Administration	Administration of oral medication with direct observation.	All Providers
	Medication Training and Support	Medication education, training and support, monitoring/discussing/reviewing side effects	MD/DO/NP/RN/ LVN/LPT
210 – Plan Development	Plan Development, non-physician	Consists of one or more of the following: development of client plans, approval of client plans and/or monitoring of a beneficiary's progress.	All Providers except MD/DO
	Care Coordination Outside System of Care	Use for coordination of care activities with providers who are outside the Mental Health system.	All Providers
	Care Management Services for Behavioral Health Conditions by Physician	Care Management Services for Behavioral Health Conditions by Physician	MD/DO/NP/RN/ LVN/LPT/Licensed, Registered, Waivered Clinician
	Medical Team Conference, Participation by Physician. Pt and/or Family Not Present	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present	MD/DO
	Team case conference with client/family absent	Team conference with interdisciplinary team, participation by a non-physician, with patient and/or family not present.	NP/RN/Licensed, Registered, Waivered Clinician
	Team case conference with	Team conference with interdisciplinary team,	NP/RN/Licensed, Registered,

	client/family present	participation by a non-physician, with patient and/or family present.	Waivered Clinician
207 – Individual Rehabilitation	Psychosocial Rehabilitation – Individual	Includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.	All Providers
208 – Group Rehabilitation	Psychosocial Rehabilitation – Group	Service provided to a group of beneficiaries which includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.	All Providers
500-503 – Therapeutic Beh Svcs	TBS	Intensive, individualized, one-to-one behavioral health service.	All Providers
N/A	Self-help/peer services	Engagement; therapeutic activity	Certified Peer Specialist
206 – Individual Therapy	Individual Therapy	Focused primarily on symptom reduction and restoration of functioning to improve coping and adaptation and reduce functional impairments. The beneficiary must be present for	MD/DO/NP/ Licensed, Registered, Waivered Clinician

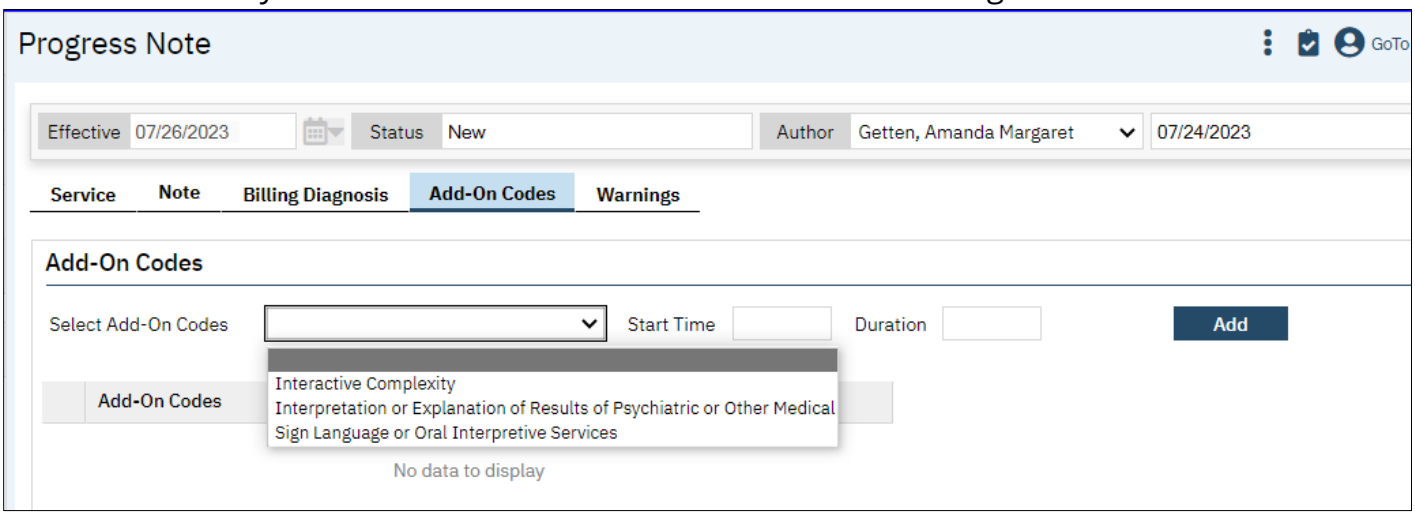
		this service.	
204 – Family Therapy	Family Therapy – client present	Directed at improving the beneficiary's functioning and at which the beneficiary is present.	MD/DO/NP/ Licensed, Registered, Waivered Clinician
205 – Group Therapy	Group Therapy	Therapy services that include multiple beneficiaries.	MD/DO/NP/ Licensed, Registered, Waivered Clinician
209 Multi-Family Group Therapy	Multiple Family Group Psychotherapy	Documentation of groups that include multiple families vs. a single family. Therapy may include family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present.	MD/DO/NP/ Licensed, Registered, Waivered Clinician
200 – Case Management	TCM/ICC	Services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development.	All Providers

Collateral, Intensive Care Coordination (ICC), and Intensive Home-Based Services (IHBS) can still be provided and billed, however they no longer have distinct service codes.

Add-On Codes

Add-on codes may also be added to some services. Add-on codes may not be claimed independently. They supplement a primary service code that is used to document a service.

Add-on codes may be added to a service note in SmartCare utilizing the Add-On Codes tab:



Add On Code Name	Description	Procedures this add on can be added to
Interactive Complexity	Used to document communication difficulties including: *Managing maladaptive communications that complicate service delivery (high anxiety, confrontation/disagreement, reactivity, repeated questions, etc.). *Caregiver emotions or behavior that interferes with ability to support the treatment of the individual in care. *Use of play equipment or other devices to overcome barriers to therapeutic interaction.	Only used by LPHA staff documenting Assessment, Medication Support, & Therapy services
Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons	Used to document interpretation or explanation of results of psychiatric or other medical procedures to a family/collateral source.	Only used by LPHA staff documenting Family Therapy, Multi-Family Group Therapy, Group Therapy, & Medication Support services
Sign Language or Oral Interpretive Services	Utilized when interpretation services are utilized but does not include interpretation by the provider – it must be a person external to the session. The external person providing interpretation services can be a county or CBO employee.	Can be used by all staff for all services when an interpreter is utilized to provide treatment.

COLLATERAL SERVICES

Definition

Collateral Services are activities provided to a significant support person in a client's life for purpose of meeting the needs of the client in achieving the goals of the client's care plan. Collateral may include, but is not limited to, consultation and training of the significant support person(s) to assist in better use of Specialty Mental Health Services by the client, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The client may or may not be present for this service activity. (CCR Title 9, 1810.206)

Collateral can be a component of many mental health services. When documenting a collateral contact, providers should select the service code that most closely fits the service provided and document in the narrative of the progress note that the service was provided to a collateral contact.

Note: Collateral can be an individual (a meeting with one client's parents) or group service (parenting class for multiple sets of parents).

INTENSIVE CARE COORDINATION (ICC)

ICC is a TCM service that includes assessment, planning, and coordination of services for youth served through a Child and Family Team (CFT) according to the Core Practice Model (CPM). ICC does not have a distinct service code; an ICC modifier will be added to a TCM service for a client in the ICC special population group in SmartCare. Special population assignments will be managed by clinic Health Information Technicians (HITs).

An ICC coordinator serves as the single point of accountability to:

- Help youth access and coordinate medically necessary services in a manner consistent with the CPM values.
- Facilitate collaborative relationships between the youth, their family, and the involved child-serving systems.
- Support the parent/caregiver in meeting the youth's needs.
- Help establish the CFT and provide ongoing support.
- Organize care across providers and systems to allow the child/youth to receive services in their home community.

ICC service components include the following:

- Review of the youth's and family's strengths and needs, as well as the capability, willingness, and availability of resources for achieving safety and permanence.
- Planning within the CPM is a dynamic and interactive process that addresses the goals and objectives necessary to assure that youth are safe, live in permanent loving families

and achieve wellbeing. The resulting plan of care must reflect the youth's and family's own goals and preferences.

- Referral, Monitoring and Follow-Up Activities. Monitoring and adapting means evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The CFT is also responsible for reassessing needs, applying knowledge gained through ongoing assessments, and adapting the plan to address the changing needs of the youth and family in a timely manner, but not less than every 90 days. Monitor intervention strategies on a frequent basis so that modifications to the plan can be made based on results, incorporating approaches that work and refining those that do not.
- Transition planning. When the youth has achieved the goals of their client plan, develop a transition plan for the client and family to foster long term stability including the effective use of natural supports and community resources.

Documenting a CFT

- The clinician facilitating the CFT will utilize the "CFT Care Plan."
- The clinician facilitating the CFT will write a TCM progress note and attach the CFT Care Plan to the TCM note/include the CFT Care Plan into the Care Plan narrative box of the progress note.
- Each staff who attends a CFT meeting will write a separate progress note that captures their individual contributions and participation in the meeting, including what information was shared and how it can/will be used in planning for client care or services to the client (i.e., how the information discussed will impact the Care Plan).
- Only one CFT Care Plan should be written for each CFT meeting. This care plan should be offered to the participants at the meeting and will be completed by the meeting facilitator.
- Appendix B provides a template for a CFT Care Plan and an example of a TCM/ICC note documenting a CFT.

INTENSIVE HOME-BASED SERVICES (IHBS)

Intensive Home-Based Services are individualized, strength-based interventions designed to help the youth build skills necessary for successful functioning and/or improve the family's ability to help the youth successfully function in the home and community.

Similar to Collateral services, IHBS is no longer documenting utilizing a distinct service code. When documenting IHBS, providers should select the service code that most closely fits the service provided. As with ICC, an IHBS modifier will be added to a service note for a client in the IHBS special population group in SmartCare.

Service activities may include, but are not limited to:

- Behavior management interventions (e.g., positive behavioral plans, modeling interventions for the youth's family and/or significant others, parent training, etc.)
- Skill training to improve self-care, self-regulation, or other functional daily living tasks
- Development of replacement behaviors or positive coping skills
- Improvement of self-management of symptoms, including self-administration of medications as appropriate
- Education about the youth's mental health disorder and illness management
- Support to develop, maintain, and use natural and community resources
- Support to address behaviors that interfere with family stability and permanence
- Support to address behaviors that interfere with seeking and maintaining a job
- Support to address behaviors that interfere with a youth's school success
- Support to address behaviors that interfere with transitional independent living objectives, such as seeking and maintaining housing and living independently.

IHBS Documentation:

- IHBS must be included on a CFT Plan of Care that is completed and updated during each CFT held at a minimum every 90 days

ASSESSMENT

Definition

Assessment is a service activity that evaluates the current status of a client's mental, emotional, or behavioral health. It includes but is not limited to, one or more of the following: mental status determination, analysis of client's clinical history; analysis of cultural issues and history; developmental issues and history, diagnosis, and the use of testing procedures. (CCR Title 9, 1810.204)

Assessment is a process that includes gathering and analyzing history, observing behavior, and obtaining information from a client and often from significant others to formulate a comprehensive view of a client's strengths and needs. The process leads to a diagnostic formulation, access criteria determination, and an initial treatment recommendation. The process may be completed in one session, or if necessary, may be completed during several contacts. Assessment is also a service, with a specific service codes in the EHR.

Assessment Documents in SmartCare

The following documents will be completed for intake assessments:

ADULT ASSESSMENTS		
Document	**Who will complete**	**Co-signature needed***
Consent to Treat	AA	

Consent for Email Communication	AA	
Consent for Text Communication	AA	
Consent for Telehealth	AA	
Coordinated Care Consent	AA	
Cost Agreement	AA	
Advanced Beneficiary Notification (Medicare Only)	AA	
Health Questionnaire (optional, as directed by clinician)	AA	
CalAIM Assessment	Intake Clinician	Program Supervisor**
Mental Status Exam	Intake Clinician	
Diagnosis Document	Intake Clinician	
CSI Standalone Collection	Intake Clinician	
NOABD (as needed)	Intake Clinician	HIT
Paper UMDAP Financial Assessment (Client and clinician signs) Completed Only if there is no funding source, Medicare only, or self-pay	Intake Clinician	Program Supervisor *Give to AA to enter in SmartCare
YOUTH ASSESSMENTS		
Document	**Who will complete**	**Co-signature needed***
Consent to Treat	AA or JSC/field-based clinician	
Consent for Email Communication	AA or JSC/field-based clinician	
Consent for Text Communication	AA or JSC/field-based clinician	
Consent for Telehealth	AA or JSC/field-based clinician	
Coordinated Care Consent	AA or JSC/field-based clinician	
Cost Agreement	AA or JSC/field-based clinician	
Health Questionnaire (optional, as directed by clinician)	AA or JSC/field-based clinician	
Caregiver Affidavit (if applicable	AA or JSC/field-based clinician	
Audio/Video Consent (if applicable)	AA or JSC/field-based clinician	
PSC-35	AA or JSC/field-based clinician	
Short Sensory Profile (Martha's Place only)	AA	
CHADIS Report (Martha's Place only)	AA	
CalAIM Assessment	Intake Clinician	Program Supervisor**
California CANS	Intake Clinician	Program Supervisor
Mental Status Exam	Intake Clinician	
Diagnosis Document	Intake Clinician	
CSI Standalone Collection	Intake Clinician	
NOABD (as needed)	Intake Clinician	HIT

UMDAP Financial Assessment (Client and clinician signs) Completed Only if there is no funding source, Medicare only, or self-pay	Intake Clinician	Program Supervisor *Give to AA to enter in SmartCare

*Associates, Trainees, and ASW Student Interns will assign clinical documentation to their Clinical Supervisor as directed by their Program and Clinical Supervisors. See P&P 14.02 for additional information.

** After the Program Supervisor, or designee, has reviewed the CalAIM Assessment, the Program Supervisor, or designee, will complete a nonbillable service must document Progress Note to document the site authorization team determination. The Program Supervisor, or designee, will attach this Progress Note to the completed CalAIM Assessment. See Appendix J for instructions on how to associate a Progress Note with a Document in SmartCare.

Assessment FAQs

- Assessment activities may be performed face-to-face, via telehealth, or by telephone, and may involve family members or other significant parties without the client. For example, staff may collect sensitive family and developmental history in a separate session with the parent of a young child rather than with the child present.
- If a CalAIM Assessment document is started but is not completed because the client terminates the contact or does not keep a follow up appointment, complete the document to the degree possible and document the reason the process is incomplete in the Summary and Recommendations domain and in the associated service note. See Policy 13.12 *Complete Health Record* for additional detail.
- Always explain the limits of confidentiality and risks/benefits of treatment at the beginning of the assessment process. Repeat as necessary to ensure that all parties involved in treatment understand the issues involved. Obtain the signature of the client/Legally Responsible Person on the Consent to Treat to document their understanding and agreement to participate in treatment.
- MD/DO/NP signature on the CalAIM Assessment is only required for clients with Medicare coverage. Otherwise, do not route the CalAIM Assessment to an MD for signature.

Assessment Progress Note FAQs:

- The total time for the assessment must be reasonable and supported by the documentation contained in the Progress Notes and in the CalAIM Assessment. Most comprehensive assessments take about 3-4 hours on average to complete. Some cases require less time, while other, exceptionally complex cases may require more time.
- If a therapist sees a client on Monday and finishes the paperwork on Tuesday (when client is not present), the time spent on paperwork is added to Monday's assessment and billed

as one **bundled** service. The write up is an important part of the assessment process, but it is not a separate, stand-alone service.

- Bundle time spent with the client/family, reviewing the client's record, and writing up the clinical assessment documentation for the total amount of face-to-face time included on the service note.

Seven Assessment Domains

The California Department of Health Care Services has created a standardized, seven-domain assessment template to be used by every county mental health plan. Utilizing a standardized assessment improves interoperability between counties and providers, allowing counties to transmit assessments across county lines to be reused to reduce redundant services that require clients to repeat processes unnecessarily.

1. Presenting Problem - why is the client requesting services? Document an account of what led up to the client seeking care in the client's own words. Addresses both current and historical states related to their chief complaint.
    - ✓ Presenting problem - the client's and collateral sources' description of problem(s), history of presenting problem(s), impact of problem on the client in care. Include duration, severity, context, and cultural understanding of the chief complaint
    - ✓ Impairments in Functioning – the person and collateral sources identify the impact/impairment – level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning
2. Trauma – document trauma exposures and the impact these experiences have on the client's presenting problem.
    - ✓ Trauma exposures– take cues from the client, it is not necessary to document the details of trauma in depth, aim for a description of the client's psychological and emotional responses to one or more life events that are deeply distressing or disturbing
    - ✓ Trauma reactions – describe the client's reaction to the stressful situations (avoidance of feelings, irritability, interpersonal problems, etc) and/or impact of trauma exposure on client's well-being, developmental progression and/or risk behaviors
    - ✓ Systems involvement – document the person's involvement with homelessness, juvenile justice, or Child Welfare Services

3. Behavioral Health History – history of BH needs and interventions that have been received to address needs.
    - ✓ Mental health history – review acute or chronic conditions not described in earlier domains. MH conditions previously diagnosed or suspected should be included
    - ✓ Substance Use/Abuse – document past/present use including type, method, frequency of use and impact of substance use on presenting problem
    - ✓ Previous services – review previous treatment received for BH needs including providers, types of services, length of treatment, efficacy/response to interventions
4. Medical History – integrates BH needs, physical health conditions, developmental history, and medication usage to provide important context for understanding the person's needs.
    - ✓ Physical health conditions – current or past conditions, treatment history, and allergies (including to medications)
    - ✓ Medications – current and past medications, previous prescribers, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. Inquire about start/end dates or approximate time frames for medication use and reason for ending use
    - ✓ Developmental history – prenatal and perinatal events and relevant or significant developmental history (primarily for individuals under 21)
5. Psychosocial Factors – understanding the environment in which the client is functioning. This environment can be micro (family) and macro (broader cultural factors)
    - ✓ Family – family history, current family involvement, significant life events within family
    - ✓ Social and live circumstances – current living situation, daily activities, social supports/networks, legal/justice involvement, military history, community engagement. Seek to understand how the client interacts with others and in relationship with the larger social community
    - ✓ Cultural considerations – identify, linguistic factors, beliefs, values, and traditions
6. Strengths/Risks and Protective Factors
    - ✓ Strengths and protective factors – personal motivations, desires and drives, hobbies and interests, coping skills, resources, supports, interpersonal relationships
    - ✓ Risk factors and behaviors – behaviors that put the client at risk for danger to themselves or others – suicidal ideation/plan/intent, homicidal

ideation/plan/intent, inability to care for self, recklessness. Also describe triggers or situations that may result in risky behaviors (loneliness, gang affiliations, drug use), and client's willingness to seek/obtain help

- ✓ Safety planning

7. Clinical Summary, Treatment Recommendations, Level of Care Determination – summarize a working theory about how the client's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed
    - ✓ Clinical impression – summary of symptoms supporting diagnosis, functional impairments, and overall assessment
    - ✓ Diagnostic impression
    - ✓ Treatment recommendations – overall goals for care and recommended services/interventions

Child and Adolescent Needs and Strengths (CANS)

An initial CANS assessment must be completed during the intake and assessment process. The CANS is a tool that helps identify child and youth strengths and needs, and it supports level of care and service planning.

ASSESSMENT UPDATES

Youth Assessment Updates

A new California CANS and PSC 35 must be completed every six months of a client's treatment episode. Documentation a LMHP must complete ***every six months*** for a youth client:

- ✓ California CANS + PSC 35

Youth BH Clinicians should complete an Assessment progress note every six months to document this assessment activity by using the Youth Assessment Update progress note template. ASSIGN CANS TO PROGRAM SUPERVISOR TO REVIEW/CO-SIGN

- Appendix D provides a template for a Youth Assessment Updates Service Note.

Adult Assessment Updates

If an adult client is being served by a LMHP, the LMHP must complete the following documentation annually:

1. CalAIM Assessment

If an adult client is not being served by a LMHP, a medication manager must complete the following documentation annually:

1. A Plan Development progress note using a progress summary note template Appendix D provides the template for documenting a Progress Summary in a service note.

TARGETED CASE MANAGEMENT (TCM)

Assisting a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of beneficiary's progress; placement services; and plan development. (CCR Title 9, 1810.249)

TCM progress notes are required to include a care plan narrative describing:

- The goals, treatment, service activities, and assistance to address the client's treatment objectives and the medical, social, educational, and other services the client needs.
- The client/legal guardian's active participation in developing these goals
- The course of action to respond to the client's assessed needs
- The client's transition plan when they have achieved their treatment objectives

Example of TCM Interventions:

- *Helped client identify needed resources and supports*
- *Discussed the importance of action (versus passivity) to reduce their depression*
- *Reminded client of their treatment gains and successes*
- *Assisted client in formulating answers and completing application*
- *Helped client develop a plan for managing anxiety while waiting for response to their application*
- *Typed and electronically filed their application (15 minutes, not billed)*

Note: Billable TCM activities related to making a referral include discussing a resource with a client, contacting the resource, completing a written referral form, helping a client access the referral and following up to make sure the connection happened. A referral is complete when the referral source accepts responsibility for providing a service (Welfare and Institutions Code 5008(d)). Multiple components of a referral completed on the same day for a client may be bundled together as part of one service note.

Completing paperwork with a client:

Clients often ask for help with forms and paperwork. If all you do is type or fill out a form for a client, then you are not providing a billable mental health service because your license and/or training are not necessary to accomplish the task.

However, the services you provide while helping a client complete paperwork or access a service may be billable as TCM. Emphasize what you did that required your specific training and professional skill. The service you provided (linking, collaborating with or teaching the client how

to access resources) is billable.

Tips for documenting paperwork completion:

- Bundle the completion of the form with a face-to-face service with the client
- Focus on the interventions you provided and how those interventions helped your client by reducing impairment or preventing deterioration
- Be specific about what prevents the client from filling out the form independently
- Write about what might happen to the client if you don't help (i.e., deterioration, need for higher level of care)
- Indicate in your note that you are billing for the interventions, not the typing

Appendix C provides Service Note examples

CRISIS INTERVENTION SERVICES

Definition

Crisis Condition means a situation experienced by the client that, without timely intervention, is likely to result in an immediate emergency psychiatric condition. Crisis Intervention lasts less than 24 hours and requires a more timely response than a scheduled visit. (CCR Title 9, 1810.209)

"Crisis intervention" consists of an interview or series of interviews within a brief period of time, conducted by qualified professionals, and designed to alleviate personal or family situations which present a serious and imminent threat to the health or stability of the person or the family. The interview or interviews may be conducted in the home of the person or family, or on an inpatient or outpatient basis with such therapy, or other services, as may be appropriate. The interview or interviews may include family members, significant support persons, providers, or other entities or individuals, as appropriate and as authorized by law. Crisis intervention may, as appropriate, include suicide prevention, psychiatric, welfare, psychological, legal, or other social services. (WIC 5008 (e))

Crisis Assessment

The Crisis Assessment document in SmartCare guides staff in completing and documenting a thorough assessment of risk to ensure high quality care and to standardize the assessment of risk to self or others.

The Crisis Assessment must be documented in SmartCare in one of the following ways:

1) Service Note: Staff can document the Crisis Intervention service and full crisis assessment in a service note using the Crisis Progress Note Template (see Appendix). For the emergency indicator on the progress note, choose "Yes."

2) Crisis Assessment: Staff can use Crisis Assessment (Client) AND enter a service note that refers the reader to the Crisis Assessment dated __/__/__. For the emergency indicator on the progress note, choose "Yes."

Additional documentation tips:

- Use client quotes, to illustrate client's responses. When known, document precipitating events and stresses.
- Clearly state behavioral observations in an objective, nonjudgmental manner.
- Document risks clearly. Do not limit your risk assessment to the presence or absence of SI/HI. Other risk factors are documented as thoroughly as possible, including:
  - ✓ The presence of mental illness
  - ✓ Past attempts, especially if serious and if medical follow up was needed
  - ✓ Access to means/lethality of means
  - ✓ Current plan/intent/preparatory behavior
  - ✓ Drug and alcohol use
  - ✓ Recent stressors, especially trauma
  - ✓ Hopelessness/lack of future orientation
  - ✓ Lack of social support
  - ✓ Demographic factors, including age and gender, which may increase or mitigate risk
- Clearly document clinical interventions (including consultations with others) and response
- Consider medical issues. Consult with BH medical staff and/or refer the client to Primary Care or Emergency Department for evaluation/medical clearance if needed
- Clearly document the follow-up plan

Develop and Implement a Safety Plan

1. Document all your follow-up contacts and consultation
2. Communicate with the entire treatment team to improve outcome and to reduce risk
3. Work with Mental Health Evaluation Team (MHET)
   - ✓ When you contact MHET, you have added a valuable resource to the client's treatment team, but you have not given away responsibility for ongoing follow-up.
   - ✓ Expect to hear from the MHET evaluator regarding outcome, but if you do not hear back, call to request information.
4. Follow up with your client promptly
   - ✓ If you were concerned enough to contact MHET or to complete a crisis service, follow up the next day by phone or (even better) face-to-face
5. Consider scheduling an urgent appointment with the psychiatrist or nurse practitioner

A prompt, well written, and objective risk assessment is the best way to ensure quality client care and to manage risk for clients in a crisis.

MEDICATION SUPPORT SERVICES, LPT/LVN/RN

Definition of Medication Support

Services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include, but are not limited to, evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instructions in the use, risk, and benefits of and alternatives for medication. (Title 9, 1810.225)

Medication Support services can be provided to a client directly or communicated to a parent or caregiver on behalf of a client. A conversation with another qualified provider (e.g. MD) about side effects or other medication related issues can also be billed as Medication Support.

Medication Refill FAQs

Question: If I get a verbal order from the MD/NP and call it in to the pharmacy, do I have to do anything else?

Answer: Yes! No matter how the prescription information gets to the pharmacy – phone, electronic transmission through SureScripts, or handwritten by the MD/NP – **all** refill information MUST be entered in SmartCare.

Preapproving the prescription and routing it to the MD:

- Ensures that the medication information is in SmartCare for all future treatment providers
- Provides the mechanism for the MD/NP to sign the order
- Protects LPT/LVN/RN staff (refill orders without an MD/NP signature = prescribing without a license)

Question: Do I have to have a signed Release of Information with the pharmacy to help get the meds refilled or to provide information for the TAR?

Answer: No, but limit the disclosure is limited to just what is needed and log the disclosure on a Record of Disclosure.

Medication Support Service Notes

If two Medication Support Services are provided for a client in the same day, both should be documented accurately in separate Progress Notes if provided by different providers.

Staff cannot combine or bundle other services (such as TCM) with Medication Support in the same Progress Note. Write one note for Med Support and a separate note for TCM.

See Medication Support Visits P&P 7.01 for more information.

PLAN DEVELOPMENT SERVICES

Definition

"Plan Development" means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress. (Title 9, 1810.232)

The Plan Development service codes are named:

- Plan Development, non-physician
- Team case conference with client/family absent
- Team case conference with client/family present

MH Service Plan Developed by Non-Physician service components include the following:

- Reviewing client's progress toward treatment objectives
- Exploring current treatment needs and objectives
- Completing an Annual Progress Summary

Choosing between Plan Development and TCM

Plan Development: Completing Annual Assessments and Progress Summaries, presenting assessments and treatment recommendations in treatment team are Plan Development services. A designated staff member writes a service note to document the treatment team's activity.

TCM: Completing a transfer summary and/or referral is TCM for all clients.

THERAPY SERVICES

Definition

Therapy focuses primarily on symptom reduction as a means to reduce functional impairments. It may be delivered to a client or a group of clients and may include family therapy at which the client is present. (CCR Title 9, 1810.250)

Therapy includes interactive processes between a person or group and a qualified mental health professional. Its purpose is the exploration of thoughts, feelings and behavior for the purpose of problem solving or improving functioning. Therapists employ a range of techniques based on experiential relationship building, dialogue, communication and behavior change that are designed to improve the mental health of a client, or to improve group relationships (such as in a family). If your scope of practice includes therapy and your technique involves teaching skills, choose the appropriate therapy service code.

Examples of Therapy Interventions

Document Cognitive Behavioral Therapy (CBT), behavior modification, and other interventions to encourage expression and to help reduce the symptoms in a therapy. For example:

- Taught the client how to "catch" automatic thoughts and redirect these thoughts.
- Reviewed 3 self-soothing skills to use to reduce intrusive memories of past abuse…
- Helped John identify at least 2 benefits from turning off TV while doing homework.
- Rehearsed next week's relaxation homework twice in the session.

Scope of Practice Issues

Only staff members whose training and licensure/registration qualify them to practice psychotherapy provide therapy services.

PSYCHOSOCIAL REHABILITATION SERVICES

Definition

"Rehabilitation" means a service activity which includes, but is not limited to:

1. *Assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills and support resources.*
2. *Medication education* (CCR Title 9, 1810.243)

Examples of Psychosocial Rehabilitation Interventions

Most interventions involve <u>teaching</u> and <u>skill-building</u>:

- Educated client about relationship of chronic anger and health
- Reviewed triggers to anger and helped develop a list of alternative coping skills.
- Showed Mark how to keep a log of xxx.
- Reviewed last week's homework and asked them to recall events that preceded their xxx.
- Discussed the red flags with them and inquired about other optional behaviors.

Scope of Practice Issues

Document relationship building, engagement, and active listening are key components of all Specialty Mental Health Services. However, the major focus of a Rehabilitation Service is the active skill building or educational component. Notes lacking a skill building or educational component (i.e., "process" notes), when written by a staff member who is qualified to provide rehab services, but not psychotherapy, create the impression that the staff member is practicing outside their scope of practice.

Attending Med Evaluations

Staff are frequently asked to join a med evaluation to support a client or relay necessary information to the MD. However, billing for two separate services (Med Support and Individual

Rehab) for the same activity is double billing. Meet with the client prior to the med evaluation and document the service as Individual Rehab. The intervention section of the rehab Progress Note documents the reason for the service (For example, "I met with xx and reviewed their list of medication-related concerns. We reviewed assertiveness skills and the use of notes/written questions to ask the MD ahead of time."). Debriefing with the client after the med evaluation could also be documented as Individual Rehab if a skill is taught. The duration on the Progress Note documenting the rehab service would include the time spent before and after the medication evaluation, but not the time the client spends in the face-to-face meeting with the doctor.

Case Consultation/Case Conference:

A "case conference" is a discussion between direct service providers, significant support persons, or other entities involved in the care of the client. It is often a formal multi-disciplinary team or Child and Family Team (CFT) meeting, but it may be a less formal discussion between providers to improve client care.

Service Codes:

- Plan Development: Use if the case conference results in updates to the client's plan of care and/or monitoring of a client's progress.
- MH Assessment: Use if the information is used to evaluate the current status of a client's behavioral health.
- Targeted Case Management (TCM): Use if the focus is coordination of services, providing linkage or referrals, etc.

Notes:

Clinical Supervision is not a case conference and is not billable. Debriefing after a stressful session is important, but it is not a case conference if the purpose is to benefit staff. It may be a case conference if the purpose is to modify treatment strategies to benefit the client.

Record Review:

When reviewing a client record prior to a service, add the time as Service Time in a Progress Note. The time spent in record review must be reasonable and must be important to client care. For example, "Reviewed record to gather treatment history for assessment…" Record review may apply to services claimed by the minute, such as:

- MH Assessment, Service Plan Development, Psychosocial Rehabilitation, and Therapy
- Targeted Case Management (TCM)
- Medication Support Services
- Crisis Intervention

Hourly and day rate services such as Crisis Stabilization, and Adult Residential cannot separately claim record review.

✧ Service Notes ✧

GENERAL CONSIDERATIONS

Service Notes are the heart of the clinical record. A service provided for a client, regardless how powerful or effective, is incomplete until documented. Effective documentation of clinical interventions is a professional, legal, and ethical responsibility of all clinical staff. Words are powerful and can unintentionally lead to biases and further stigmatize individuals. Progress notes should use of person-centered, strength-based language that acknowledges clients are more than their symptoms or mental illness. It is not necessary to restate the client's impairment or diagnosis on each progress note.

Service notes must document the medically necessary service provided and the planned next steps. Service notes do not need evidence access criteria. They should be written in plain language to describe to the reader what was discussed, what happened during the service, and next steps. SLOBHD Progress Notes are not process or "psychotherapy notes" defined in HIPAA (CFR 45 §164.501). Co-occurring treatment allows SMHS providers to address substance use disorder needs within a progress note documenting a mental health service and vice versa.

Functions of a service note:

1. Care Planning – service notes provide a basis for planning treatment among providers and across programs. Notes should be understandable when read independently of other progress notes. Notes should provide an accurate picture of the service provided and the future plan of care.
2. Communication – service notes allow communication between providers to coordinate care, avoid duplication of services, and improve outcomes by reflecting the service provided and next steps.
3. Reimbursement – service notes are required for verification of services as a part of the client's legal health record.

Who are service notes for:

1. Client – client access to health records will increase with technological advances and the implementation of a patient portal. Access to health care records can empower clients to be more in control of their health care services.

2. Treatment team – service notes serve to keep all providers informed.
3. Yourself – documenting what happened helps clinicians formulate next steps and can serve as a reminder of past services.

What should **not** be included on a service note:

1. Lengthy narrative
2. Copy and paste from previous notes
3. Jargon that make notes difficult for others to understand
4. A specific note format is not required – simply documenting the service and interventions provided and plan for next steps is required.

Service note content requirements:

1. Service code
2. Date of service
3. Duration of service
4. Location of client at the time of receiving the service
5. Typed/printed name and signature of provider and date of signature
6. ICD 10 code
7. Narrative describing the service, including how the service addressed the client's behavioral health need – the description of the service provided should support the service code used
8. Next steps including, but not limited to, planned action steps, collaboration with the client, collaboration with other providers, and any update to the problem list/diagnostic review as appropriate

Frequency

Document every outpatient service contact in a Service Note. Residential and STRTP programs are required to complete daily progress notes.

Timeliness – It is essential for clinical information to be in the chart as quickly as possible to ensure we are best able to meet the needs of clients and coordinate care. Timeliness is tied to the author of the note who is working with the client, if the author has completed and signed the note within the timeline requirements, the requirement is met, even if a co-signer has not signed off or if the note has not been final approved.

Routine Services: Must be completed within three business days

Crisis Services: Must be completed within 24 hours

Sample timeline for a service provided on Friday, 8/26/22 at 9 AM

- Routine Service: Must be written and signed off by the staff who provided the service by Wednesday, 8/31/22.
- Crisis Service: Must be written and signed off by the staff who provided the service by Saturday at 9 AM.

If a service note is written after the required timeframe, it is good practice to document the reason for the delay (health reasons, IT barriers), extensive detail is not required.

Accuracy of Billing Information

The service, travel and documentation time in a Progress Note must accurately reflect the time spent providing the service and must be reasonable for the service provided. The service note documentation must support the amount of service time that is being claimed. When a service is a long length of time due to the client's presentation or due to specific circumstances, but minimal interventions were provided and documented, this additional information must be included in the note. Examples:

- The service time for an Assessment service was long because the client was frequently perseverating and distracted:
  - "This Clinician minimized distractions as much as possible and prompted the client to return/refocus on the assessment process throughout the session because the client was distracted and perseverating throughout this service."
- An Individual Therapy service was a long length of time because the client was dysregulated throughout most of the session:
  - "This Clinician focused the majority of session interventions and time on helping and the client regulate his/her/their emotional state as the client presented as highly dysregulated today."
- A Medication Training and Support service was long because the client was reporting medication concerns/side effects:
  - "This LPT gathered the list of client medication concerns and side effects that she is experiencing, and communicated these to the MD/NP who was available for consultation."

For group counseling, the Progress Note must accurately record the amount of time each group member participated in the group. Therefore, if one client is excused to leave a group early or arrives late, the time attended must be changed. Similarly, if a client did not attend group, the time for the client must reflect 1 service minute in addition to capturing the appointment type (no show or cancelled).

Additional Billing Information Tips:

- Billable services must include an intervention that addresses a clinical need for the client.
- Clerical tasks are not billable because no intervention occurred that would benefit the client.
- Services bill by the number of minutes the service actually took. It is not acceptable to enter an estimate of the amount of time a future service might take. Refer to the Health Agency's *Fraud, Waste and Abuse Policy* for additional detail.

Appropriate Language in Documentation

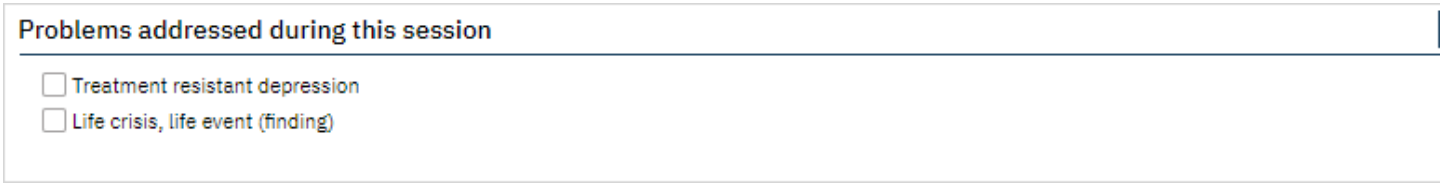
- Third Party Information: State information gathered from third parties as a report, not a fact (e.g., "Client's father reports that ….").
- Abbreviations: Standard abbreviations are acceptable in a note. See Appendix E for the list of abbreviations. If you need to abbreviate a word or use an acronym that is not on this list, spell it out first.
- Recovery Language: Document using strength-based language that reflects the culture of the client and respect for the collaborative process.

INDIVIDUAL SERVICE NOTES

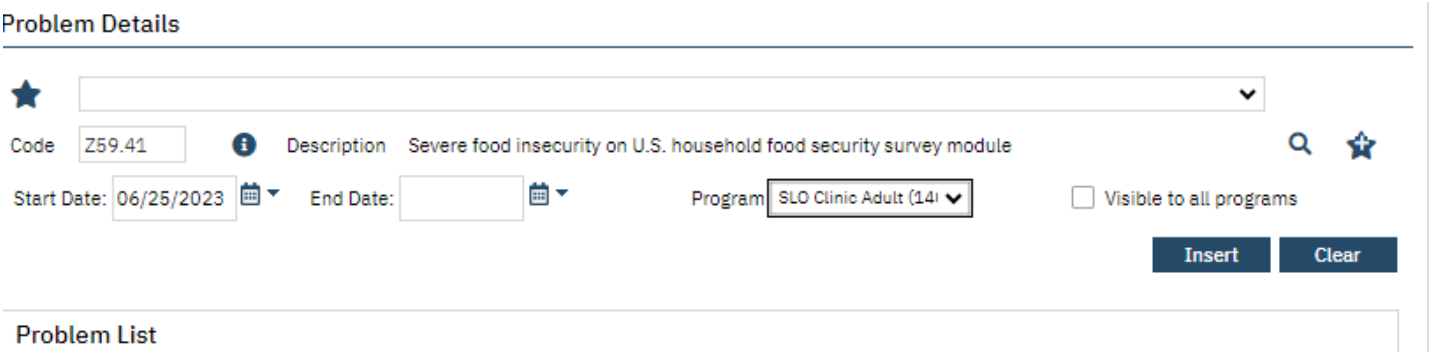
Service Notes, also referred to as Progress Notes, in SmartCare have three sections that must be completed:

1. Service Tab – contains important billing and Client & Service Information (CSI) reporting data. Appendix F lists and defines all the Service Indicators.

2. Note tab – allows the provider to identify the problem addressed during the session. A problem may be selected from the list:



If the provider addresses a new need this problem may be added to the list from the progress note by entering the name of problem in the "Description" or the ICD 10 code in the "Code" search fields, selecting the appropriate problem, and clicking "Insert" to add the problem to the selection list below.



The Note tab also contains two narrative sections for providers to complete:

a. **Information** - Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

It is not necessary to write an extensive narrative of dialogue during a session or to restate the client's diagnosis or impairment in each note. Services are what staff do for the client during the contact to reduce the client's impairments due to mental illness or prevent deterioration in functioning. Clearly written interventions are the primary proof that the service provided was medically necessary. Bulleted phrases or narrative text are equally acceptable writing styles. Generally, Interventions are phrases that begin with an action word.

Examples of Interventions include:

- Reviewed record to gather treatment history for assessment…
- Prompted…
- Confronted…
- Asked…
- Taught…
- Modeled…
- Reviewed progress…
- Discussed…

b. **Care Plan** – This section serves two purposes.

i. Completing this section is required in order to sign and finish the progress note.

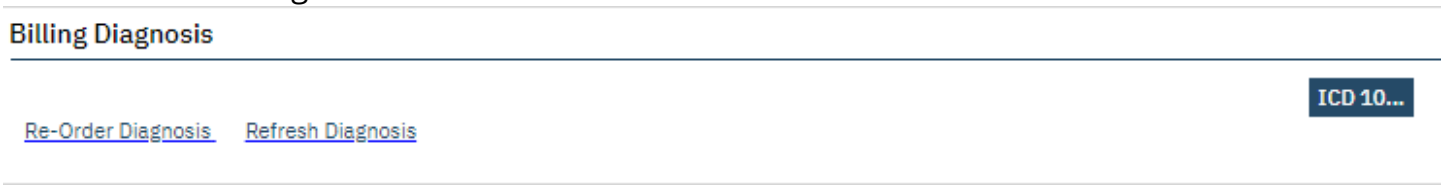
ii. This section tells the reader what to expect in the next note or coming weeks. It might include upcoming appointments, homework, or items that need follow up. Examples:

- Next appointment is scheduled with _____ on _____.
- Staff will continue to support client/provide services to address _____.
- Staff will continue to provide individual therapy, medication management, and case management to support the client with

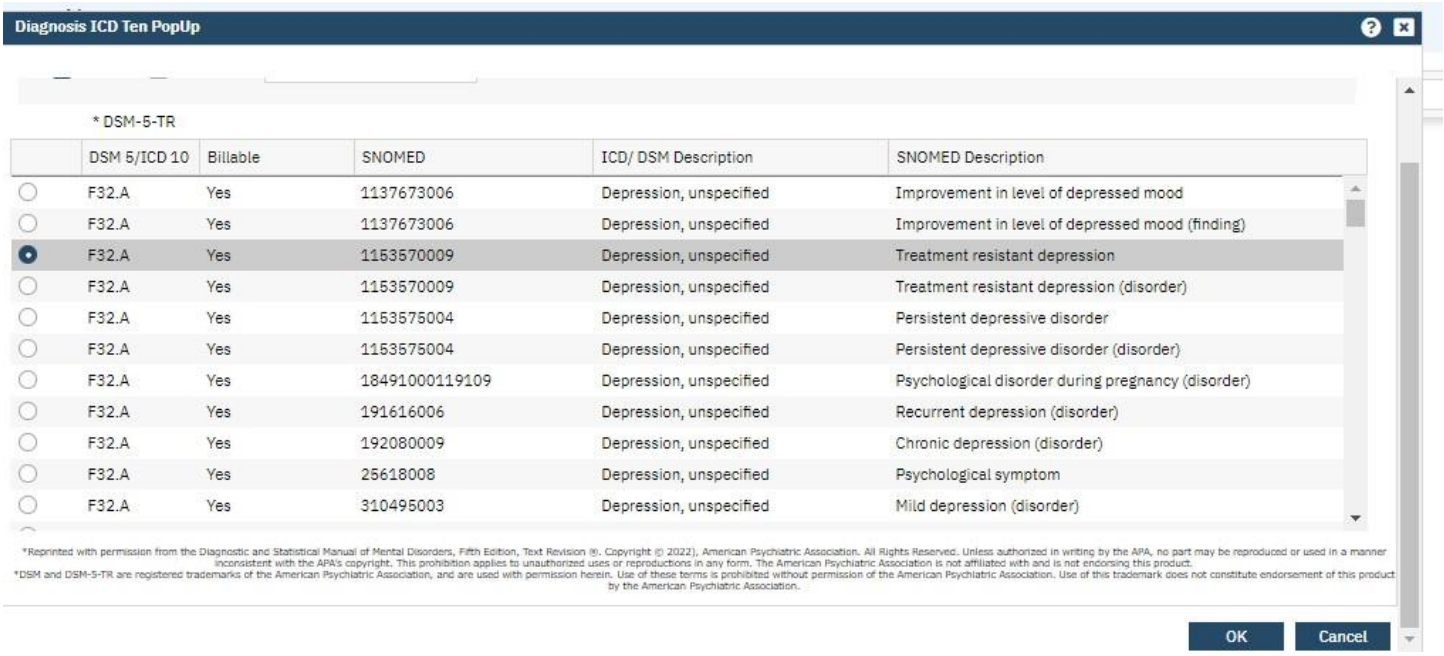
improving functioning in the areas of _____ / reducing symptoms of _____.

iii. This section is also where the writer provides a care plan, which is required for TCM/ICC services. SmartCare includes the following prompt for this field, which assists the writer in capturing the required elements of a care plan for TCM/ICC: Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

3. Billing Diagnosis tab – this tab lists the ICD 10 diagnoses listed on the Diagnosis Document and shows you which diagnoses will be pulled onto the billing. You should generally ignore this tab for ongoing services. However, if you need to change the billing order, for example you want this note to focus on the secondary diagnosis, you can re-order the diagnoses to match your service without changing the overarching diagnosis form. If a provider is documenting a service provided prior to establishing an ICD10 diagnosis, the provider may add a one-time billing diagnosis here by:
   - Clicking on the ICD 10 link

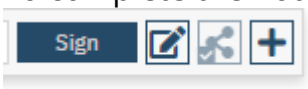


   - Searching by ICD10 code or name
   - Selecting appropriate diagnosis and clicking “OK”



Providers may only add diagnoses that it is within their scope to identify. *See Problem List/Diagnosis Document section in these guidelines.*

To complete the note, simply click "Sign," and a PDF of the note will be created.



To add a co-signature, or ensure your clinical supervisor's co-signature has been added to the note, click the "More Detail" + icon to the right of Sign (shown above).

Electronically sign progress notes as soon as possible <u>after the content is complete</u> to create a date and time stamp that verifies when you wrote the note. You may edit a progress note that you were the author of by selecting the "Edit" icon next to Sign (shown above). This will create a new progress note document. The original progress note document will be saved in the client's record, but will be replaced by the new, edited version on the Service Note list page.

GROUP PROGRESS NOTES

Group Note section:

- ✓ Write the purplose of the group here:
  - The goal of group is to develop conflict resolution skills to help clients improve social relationships.
  - The group focused on teaching budgeting skills to help clients maintain housing.
- ✓ List group interventions: Write your specific skill building interventions for the <u>entire</u>

group here:
    - Taught the group to develop a budget by listing expenses…"
    - Modeled effective communication
    - Rehearsed …
    - Role played …
    - Practiced …
- ✓ When utilized, add a reasonable amount of time spent preparing for a group session to Service Time and document what you did as a group intervention in the Group Summary. Appropriate activities include researching and modifying material to make it appropriate for the group. Clerical functions (photocopying, shopping for supplies, and setting up the room, etc.) are not billable interventions and are not included in the progress note.

Client Note section:

1. Individualize the note by listing any interventions or decisions for each group member.
2. Document a brief description of how the client responded to the service. Each client has unique interactions with other group members and reactions to the topic; document the individual responses as appropriate.
3. Document the plan/next steps for the client related to treatment.

When two staff provide a group service, one note may be written by one provider. The progress note must clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. The service must be within the scope of practice of both staff.

NON-BILLABLE SERVICES

There are two ways to document non-billable service notes in SmartCare:

1. Client Non Billable Service Must Document procedure code
2. Targeted Outreach procedure code

Non-billable services include:

- Leaving a message or listening to voice mails
- Clerical tasks (e.g. reminder calls to clients, faxing)

Note: When a clerical activity is a part of a longer billable service, it is not necessary to write a separate Informational Note. Document the clerical activity, but clearly indicate that the clerical activity was not billed.

✧ Requests for Services ✧

COMPLETING AN INQUIRY
An inquiry is completed for each new request for services by a client not currently open to a MH program. Inquiries are generally completed by central access line staff.

When a client/parent/guardian requests services, or when a referral is received by a community provider, Central Access Line staff complete these steps to document this new referral in an Inquiry document in SmartCare:

A. Central Access Administrative Assistant (AA):
    1. Completes AA portion on Initial, Insurance, and Demographics tab
        - Initial tab – Includes referring agency information, if applicable
        - Insurance tab – Verify Medi-Cal and enter
        - Demographics tab – Enter basic demographic information
    2. Creates a client medical record ID, if applicable
    3. Enrolls client into a SLO MC Authorization program
B. Central Access BH Specialist:
    1. Completes an Adult or Youth Screening Tool (see policy and procedure (P&P) 3.05)
    2. Completes disposition portion of Initial tab of Inquiry document
    3. Schedules assessment/screening with the outpatient program
    4. Enrolls client in an outpatient program, if applicable
    5. Assigns client to program staff
    6. Closes SLO MC Authorization program assignment
    7. Completes the CSI Standalone Assessment fields, ***only when a MH assessment is offered and the client declines to schedule***
    8. Completes a TCM service note

Outpatient staff will find clinical information regarding the client's request for services by reviewing the Adult or Youth Screening Tool document and the TCM service note.

✧ Special Documentation Scenarios ✧

Urgent Follow-up Services:
If a client has been recently discharged from the PHF, an out of county psychiatric hospital, the crisis stabilization unit (CSU), a hospital, or emergency department (ED), has been released from jail, or recently received a crisis service with the Mental Health Evaluation Team (MHET) these appointments are referred to as "Post" appointments; e.g. Post PHF/hospital/ED/jail/MHET/CSU follow-up appointments. Timely outpatient follow-up after a hospitalization or significant event

is critical to assist clients in maintaining the treatment gains achieved during their inpatient stay or crisis intervention service, and to address client needs and decrease risk factors to avoid decompensation and hospital readmissions.

When a client who was not previously open for outpatient services attends a post PHF/hospital/ED/jail/MHET/CSU follow-up appointment, staff will address any emergent needs and provide services to ensure continuity of care. This may include arranging for a medical staff member to refill medications, scheduling an psychiatric evaluation for medication, and scheduling a comprehensive intake assessment with a clinician. Already-open clients will meet with their current team for follow-up. Appendix G describes the procedure for post PHF/Hospital/CSU/ED/MHET/Jail follow up services, outreach, and documentation.

✧ Problem List / Diagnostic Review✧

A **Problem List** is required for all services for all clients. Problem Lists replace treatment plan requirements for many SMHS. A Problem List in addition to a plan of care is required for clients receiving these services:

- Targeted Case Management
- Intensive Care Coordination
- Intensive Home-Based Services
- Therapeutic Foster Care
- Therapeutic Behavioral Services
- Peer Support
- Short Term Residential Treatment Programs
- Psychiatric Health Facilities

Problem List Description

- A list of symptoms, conditions, diagnoses, and/or risk factors identified during service encounters.
- Codifies the client's needs so our health record can be interoperable with other providers serving the same client.
- Utilizes SNOMED codes in addition to ICD 10 codes. Each ICD 10 code has many associated SMOMED codes.

Problem List Requirements

- A problem or need identified during a service encounter may be addressed by the provider during that service and subsequently added to the Problem List – staff may address client needs before they appear on the client's Problem List.

- Problem Lists are not required to be updated within a specific time period; they are dynamic lists that should be updated as the client's needs change.
- Providers shall add to or end date problems from the Problem List when there is a relevant change to a client's condition/needs.
- Includes:
    - Mental Health diagnoses
    - Substance Use Disorder diagnoses
    - Physical Health conditions
    - Social Determinants of Health Z codes
- Must contain:
    - Name and job title of the provider who identified, added, or removed the problem
    - The date the problem was added or removed

Social Determinants of Health (SDOH) Z Codes

- Z00-Z65.8 – Factors influencing health status and contact with health services
- Used to provide a more comprehensive view of the psychosocial problems impacting our client's needs and impairments
- May be added to the Problem List by any staff serving the client, regardless of job title or license/registration status
- Appendix H provides a list of Social Determinants of Health Z code diagnoses and their associated SNOMED code
- To save time, search for the Problem using the SNOMED code

Completing Diagnosis Document in SmartCare

The Diagnosis Document contains information needed for billing and CSI reporting purposes. To change or update a diagnosis, create a new Diagnosis Document.

Clients Shared by MH and DAS

The Diagnosis Document must accurately reflect the client's clinical presentation, meet the documentation standards of both MH and DAS, and support billing/reporting functions for all

servers involved in a client's treatment. Collaboration to determine an agreed upon diagnosis for clients shared by MH and DAS is vital.

Completing Diagnostic Reviews for Shared Clients

Client opened and diagnosed by MH, later diagnosed by DAS

DAS staff:

- May add, edit, or end Substance Use Disorders
- May add MH diagnoses (LMHP staff only) but cannot change the MH diagnoses set by MH staff (MH may have billing tied to this diagnosis) without first consulting with MH staff.

Client opened and diagnosed by DAS, later diagnosed by MH

MH staff:

- May add, edit, or end MH diagnoses
- May add Substance Use Disorders but cannot change Substance Use Disorders set by DAS staff (DAS may have billing tied to this diagnosis) without first consulting with DAS staff.

Diagnosis at Assessment

During the initial assessment, the intake clinician documents symptoms and impairments to formulate an ICD10/DSM 5 diagnosis. It is important to render all diagnoses supported by the clinical presentation.

Staff must review every active diagnosis for consistency each time a Diagnosis Document is completed. Carefully evaluate multiple diagnoses within a class to determine if contradictory diagnoses exist. Often, rendering a specific diagnosis should result in removing a more general diagnosis of the same class. Some diagnoses have exclusions and cannot occur at the same time as another diagnosis.

Case Example: Unspecified Mood (Affective) Disorder was diagnosed during a crisis contact. A thorough review at assessment determines that criteria for Major Depressive Disorder, single episode, moderate, are fully met. Remove the diagnosis of Unspecified Mood Disorder because Major Depression is a more specific diagnosis.

Diagnostic Review FAQs

1. **How often must a Diagnosis Document be completed?**
    - When first receiving services
    - Whenever a change of diagnosis is indicated

2. **Who completes and signs a Diagnosis Document?**

    Staff complete Diagnosis Documents within established scopes of practice.

- Physician, Psychologist, LCSW, LMFT, LPCC, and NP staff render and update mental health and substance use disorder diagnoses. Registered Associates and Trainees in one of the above disciplines render diagnoses "under the direction of" their clinical supervisor.

Notes:

- MD/DO/NP signature is not needed if another LMHP signed a Diagnosis Document
- In many instances, the Diagnosis Document will reflect the working diagnosis of the MD/DO/NP, but in all cases, the team will collaborate when there are professional differences of opinion about a diagnosis.

3. How do I document Medical Conditions?

Medical conditions may be recorded on a Diagnosis Document in two ways.

A. Other General Medical Conditions text box:
- Allows staff to document the **client's report** of medical problems in the client's own words.
- Does not imply that the staff member quoting the client is making a medical diagnosis.
- **Optional** (highly recommended)
  Example: "Client reports high blood pressure, asthma and diabetes."

B. Specific ICD10 Diagnoses added to the Diagnosis List
- Allows staff to record specific ICD10 medical diagnoses previously given to a client by their primary care physician (PCP) or other medical provider. Records from the MD making the medical diagnosis are typically used as a reference.
- Allows medical staff to render a medical diagnosis.
- **Optional** (Not recommended without detailed information from medical provider unless rendered by medical staff)

✧ Closings/Discharge Summary ✧

When to complete a Discharge Summary:

When a treatment team recommends ongoing services and treatment later ends, staff will document the discharge in a service note. Program assignment changes are not discharges (see Transfer process, below).

Discharge Service Note:

Elements to include on a Discharge Service Note:

1. Reason for discharge: The reason for a client's discharge is part of our required CSI state reporting and requires us to identify the reason for the client's discharge from this list of reporting options:

- Administrative discharge
- Client not appropriate for treatment
- Deceased
- Discharged against medical advice
- Disengaged from services/Non-compliant with treatment
- Incarcerated
- Involuntary discharge
- Moved Out of Area
- Never engaged in services
- Services no longer needed
- Transfer to higher level of care
- Transfer to lower level of care
- Transferred to a different program

2. Summarize treatment and document all closing discussions with client, treatment team, and other treatment providers.
3. Document contact attempts with the client on the Discharge Summary
4. Assign the Program Supervisor to the Discharge Service Note for review.
5. The Program Supervisor reviews, signs, and then routes the Discharge Service Note to the HIT to process the closing.

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

Client has received therapy, medication management, and case management services with SAFE since April 2022. Client has actively engaged in services and has made some progress toward meeting their treatment goals. Client's family has made a plan to move to San Diego County and will be seeking ongoing mental health services in their new county. This writer has met with the client for a final treatment session and has assisted the family in requesting ongoing mental health services with the San Diego County Behavioral Health Access Line.

Care Plan

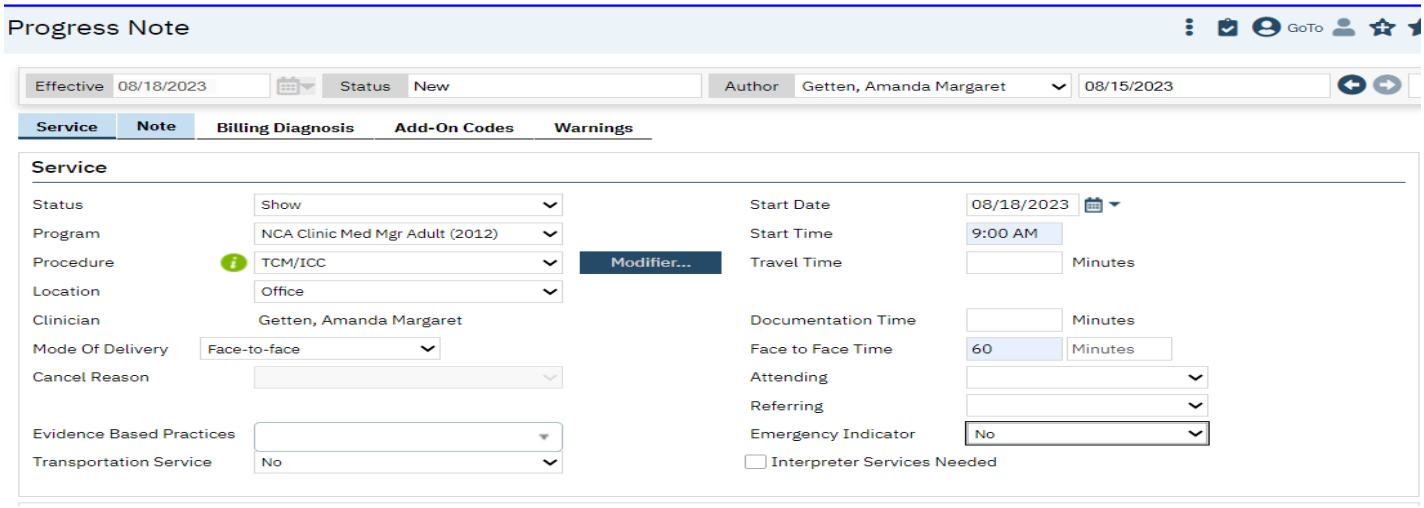
Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

This writer provided case management services to assist the client in accessing the following needed service(s): Medication Support and case management services with San Diego County Behavioral Health.
The service activities included: Coordination of care to facilitate a transfer of client's SMHS from SLO County to San Diego County Behavioral Health.
This writer collaborated with the following person(s) to develop the goal(s) of this case management service: Client, current prescriber, and the San Diego County Behavioral Health Access Line.
Identified course of action: Client is scheduled for an intake assessment with San Diego County Behavioral Health on (date) at (time).

See P&P 5.02 Outpatient Discharge Planning for additional direction.

✧ Transfer of Client Service ✧

Transfers between SMHS programs:
Whenever a client's care transfers from one program to another, take steps to ensure continuity of care and complete a TCM/ICC Service Note:



Include a summary of treatment and document all transfer discussions with the client, treatment team, and other treatment providers on the Note tab of the Progress Note:

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

Client has received therapy, medication management, and case management services at the SLO Adult clinic since June 2021. Client has made good progress toward meeting their treatment goals and has stopped receiving therapy services. Client continues to meet access criteria for SMHS due to ongoing symptoms of depression that impacts their ability to work, leave the house, and complete activities of daily living. Client continues to receive medication support and case management services to address their ongoing treatment needs. Client has made a plan to move to Atascadero and has requested their services to be transferred to the North County Adult clinic. This writer has met with the client for a final treatment session and has coordinated this transfer with current and new treatment teams.

Care Plan

Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

This writer provided case management services to assist the client in accessing the following needed service(s): Medication Support and case management services with the North County Adult clinic.
The service activities included: Coordination of care to facilitate a transfer of client's SMHS from the SLO Adult clinic to the North County Adult clinic.
This writer collaborated with the following person(s) to develop the goal(s) of this case management service: Client, current prescriber, and the North County Adult clinic treatment team.
Identified course of action: Client is scheduled to meet with their new medication manager at the North County Adult clinic on (date) at (time).

After completing the TCM/ICC Service Note:

1. Assign the Program Supervisor to the TCM/ICC Service Note for review.
2. The Program Supervisor reviews, signs, and then routes the TCM/ICC Service Note to the HIT to process the transfer.
3. The HIT will then route the TCM/ICC transfer note to the receiving Program Supervisor and HIT.
4. The receiving Program Supervisor will complete a nonbillable service must document Progress Note to document the staff assignment plan. The Program Supervisor will attach this Progress Note to the TCM/ICC transfer note. See Appendix J for instructions on how to associate a Progress Note with a Document in SmartCare

Transfers to Non-Specialty Mental Health including CenCal Health or CHC:

The Transition of Care for Medi-Cal Mental Health Services is intended to ensure that beneficiaries who are receiving mental health services from one delivery system receive timely and coordinated care when their existing services need to be transitioned to the other delivery system. See P&P 3.05 Adult and Youth Screening and Transition of Care Tools for additional guidance. A Transition of Care document will be completed and sent to CenCal or CHC when a client has made progress in treatment, no longer meets access criteria for SMHS, and would benefit from ongoing mental health treatment at a lower level of

care with a non-SMHS provider. The Transition of Care document is designed to be used for adult and youth referrals to CenCal and CHC, and provides clinical information including:

- Referring plan contact information and care team
- Beneficiary demographics, contact information, and cultural and linguistic requests
- Beneficiary behavioral health diagnosis, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications
- Services requested

The Transition of Care document is also utilized when an assessing clinician determines that a client does not meet access criteria for SMHS and would benefit from a referral for non-SMHS.

See Appendix I for examples of completed Transition of Care documents.

Appendix A – Client Consent

LPS conservatees:

- An LPS conservatee's signature is optional on the Consent for Treatment.

Youth Client Signature on Consent for Treatment:

- Minor under age 12:
  - Staff rarely obtain signature of a minor less than 6.
  - Staff obtain and document participation and agreement for a minor 6 or older but less than 12 as best practice for clinical reasons, but it is not a legal requirement.

- Minor 12 or older:
  - Staff will obtain the client's signature unless the client is unavailable or refuses to sign.
  - Occasionally, a minor age 12 or older is unable to participate intelligently in treatment planning due to symptoms of his/her mental illness or lack of maturity. If the client is unable to participate meaningfully after attempts to engage, use the "Document Client Non-signature" option. Staff may provide services with only the P/LRP signature the Consent for Treatment in this instance.
  - For a minor under 12 or not mature enough to participate in treatment planning, no P/LRP participation and agreement = no treatment.

	Minor less than 12	Minor ≥ 12, not mature enough to participate in planning	Minor ≥ 12, mature enough to participate in treatment planning independently:	
			Not minor consent	Minor Consent
Minor	<6: Not Obtained ≥6: Not Required	Best Practice	Required	Required
Parent / Legally Responsible Person	Required		Best Practice	Not Obtained

Minor Consent services:
There are two different laws that allow minors to consent for treatment on their own signature. Both require the therapist to involve the parent in treatment unless the therapist determines that parental involvement is inappropriate. Clearly document the decision and any efforts to involve the parent in Progress Notes. If parental involvement is inappropriate, staff will not obtain the P/LRP signature on the Consent for Treatment. Program Supervisor approval is required for Minor Consent services.

❖ **Notes:**
  - Minor consent is limited to outpatient services and excludes psychotropic medication, ECT or psychosurgery.
  - When a minor could have consented for his or her own services, but did not, discuss the risks and benefits of treatment with the minor and the parent and then obtain

both the minor's and the Parent's/Legally Responsible Person's signature on the Consent for Treatment.

- When a minor consents for his or her own services, the record must document:
  1. An explicit statement that the professional person believes the minor is mature enough to participate intelligently in outpatient services. *(Family Code § 6924 and Health & Safety Code § 124260)*
  2. A statement that the minor would present a danger of serious physical or mental harm to self or others without the mental health treatment, or is the alleged victim of incest or child abuse. Services can only be billed to Medi-Cal if the minor meets the stricter *Family Code § 6924* requirements and has Minor Consent Medi-Cal. *(Family Code § 6924 / Minor Consent Medi-Cal services only; <u>not</u> applicable to Health & Safety Code § 124260 services)*
  3. The attempts to involve the parent and the outcome of the attempts, or the reasons why the provider thinks it would be inappropriate to involve the parent in the minor's treatment. *(Family Code § 6924 and Health & Safety Code § 124260)*
- When a minor consents (or could have consented) for his or her own services, the minor controls access to the record and <u>must</u> sign all Releases of Information prior to third party disclosure (excludes mandated reporting and "must" disclosures).
- When a minor could have consented for his or her own services, but did not, usually the best choice is to discuss potential third party disclosures with the minor and the parent, and then obtain both the minor's and the Parent's/Legally Responsible Person's signatures on the Authorization to Use/Disclose PHI.
- When a minor consents for his or her own services, the minor's written authorization is required before disclosing outpatient treatment information to a parent. Involving parents in treatment will necessitate sharing certain otherwise confidential information; however, having them participate does not mean parents have a right to access all confidential records. Providers should honor the minor's right to confidentiality to the extent possible while still involving parents in treatment – disclose the minimum necessary to accomplish the treatment purpose. If the client presents as a danger to self, others or as a gravely disabled minor, W&I 5585 requires information to be shared with a parent or legal guardian. A separate exception to confidentiality applies to Drug & Alcohol treatment information (42 C.F.R.§2.14).

When a minor (age ≥ 12 but <u>not</u> mature enough to consent for treatment independently) objects to a parent's request for disclosure to a third party, the record must document:

- The specific behaviors/symptoms that support the professional person's opinion that, as a result of his/her illness, lack of maturity, or other related factors, the minor lacks the maturity necessary to consent to treatment intelligently.
- Any attempts to obtain the minor's signature on the Release of Information.
- The reason the professional person intends to disclose the information despite the minor's continued objection.
- Example: "Client's ongoing depression, thought disturbance and unrealistic beliefs about their ability to care for themself make them incapable of making intelligent, independent treatment choices. Their parent signed a release of information to provider X – the client

objects, and is unwilling to discuss the disclosure rationally. The disclosure is needed to coordinate appropriate treatment, and will be made at the parent's request because the minor does not qualify for minor consent under the circumstances."

Explaining Confidentiality to Minors

I want to talk to you about the word **confidential** and what it means when you come to see me. The word confidential means that when you share something with me, I cannot tell other people because it is your private information. This is a safe place to talk about your feelings, thoughts, experiences, family, or anything you want to talk about or need help with, and I want you to feel comfortable talking to me. A lot of the things we talk about will be confidential, so they will just be between me and you, but there are some things that are not confidential, which means that I would need to tell another adult. One of those times that I would need to share with another adult is if it's about safety, because your safety is really important to me. For example, if you tell me that someone is hurting you, I am going to be so thankful that you told me and I am going to talk to another adult so we can make a plan to keep you safe. Or if you tell me that you want to hurt yourself or somebody else, again I will be so happy that you shared with me, and I will need to talk to another adult to make a plan to help keep you or others safe. Does that make sense? Do you have any questions about what I've told you so far?

I also want to tell you about what we call records. When you come into the office to see me, I will take notes because everything you say is really important to me and I don't want to forget. After you leave the office I put the notes into the computer to keep them safe. When they are in the computer sometimes there are other people who work here who can see them too so that if they need to help me or you with something they are prepared. (Only for Foster Youth: It's important for you to know that even if your foster parent works here, they are not allowed to go into your notes, but if you are working with them here too, then they may be the ones putting your notes into the computer.) Those notes are called records. I can write the notes by myself, but I wanted to let you know that we can talk about what goes in the notes together if you want, so that you feel comfortable knowing what they say or don't say. For example, if you would like to go by a different name or different pronouns than what your family calls you, but you aren't ready to share that with them yet, you can let me know and I will not put that in your health record. I also want you to know that we might get to talk about a lot of things together, but not everything we talk about will go in the notes. I want to keep most things you tell me confidential, or private, and so I will remember a lot of it, and only need to write down things that I teach you or things that you are practicing, like learning new feeling words and what to do with big feelings, different ways to calm down, or how to solve problems or conflicts with family or friends. Do you have any questions about what type of things will go in the notes, and what type of things I will remember that I don't need to put in the notes?

Sometimes your family may want to see the notes so they know what we are working on together, I want to make sure you understand what they are allowed to see and what they are not allowed to see. Sometimes kids will tell me that's it's ok if their parent or guardian sees the notes, and sometimes kids will tell me they are worried about someone seeing the notes, so if you ever have a question about what you share with me it's always ok to ask me. Do you think you would be comfortable asking me questions about your notes?

We talked about the word **confidential** and the word **records**. I know it was a lot of information. Do you have any questions for me?

Appendix B – Documenting a CFT

Child & Family Team Care Plan Template

Specialty Services: **(Indicate which service the client will be/is receiving)**

- □ Intensive Care Coordination
- □ Intensive Home-Based Service
- □ Therapeutic Behavioral Services
- □ Therapeutic Foster Care

Date of CFT:

CFT Participants (Name and role on team):

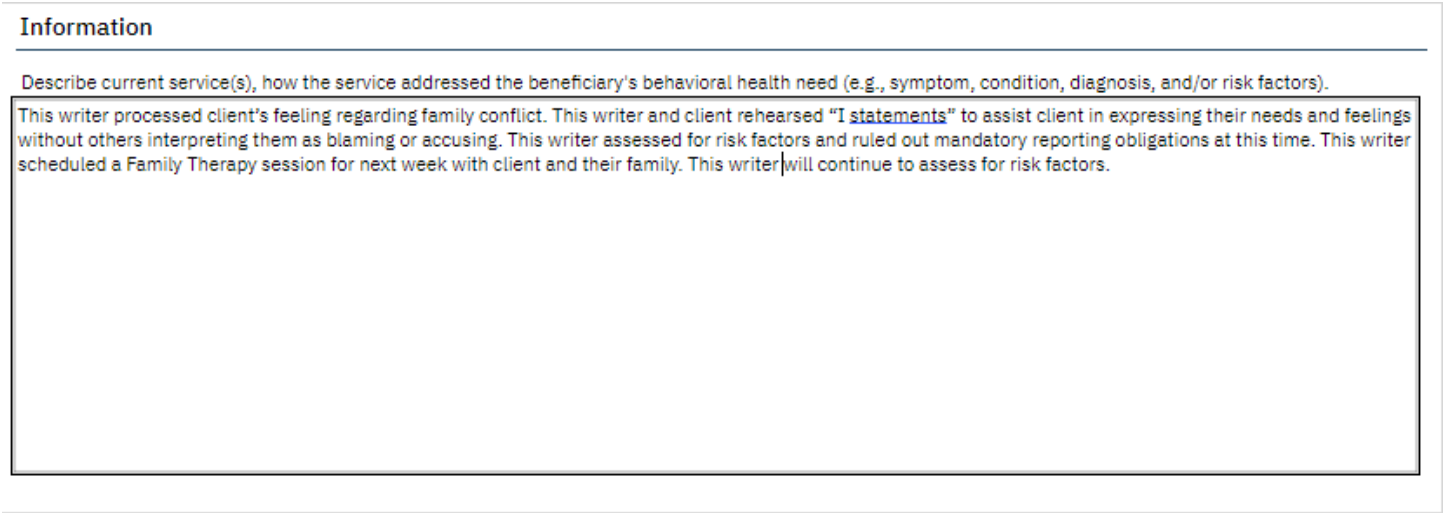
Follow up on action plans from previous CFT meeting:

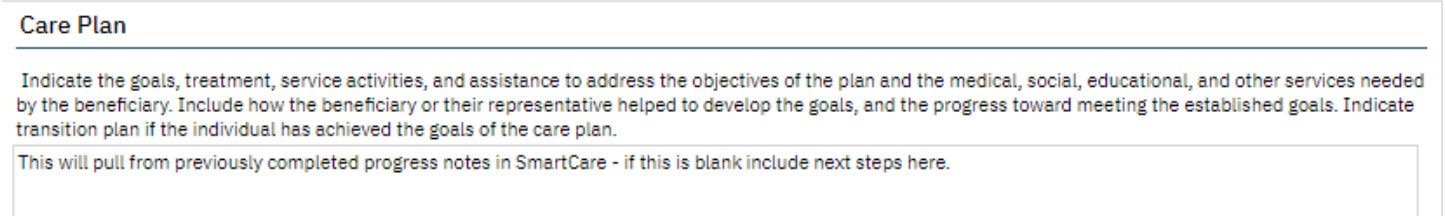
Family and client strengths:

Family and client driven plan

Identified needs: (include CANS items rated 2/3, describe needs the client and family team would like to focus on, describe changes in needs since last CFT)

Action plan and next steps: (include which person(s) is/are responsible for next steps and each part of the action plan)





Step Down Plan for end stages of IHBS and TBS: (note amount of decrease in service hours)

Next CFT meeting date/time:

Example of a TCM/ICC Progress Note documenting a CFT:

Appendix C – Service Note Examples

Assessment Service Note Example:

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

This writer reviewed consents and informing materials with client/client's parent or guardian to ensure their understanding. Prior to the face-to-face assessment, this writer reviewed client's medical record to identify historical clinical information, safety concerns, and treatment history. This writer completed the intake assessment - see CalAIM assessment dated 7/3/23. This writer scheduled a follow up appointment with client/family on 7/11/23 to discuss treatment recommendations and next steps.

Care Plan

Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

This will pull from previously completed progress notes in SmartCare - if this is blank include the outcome of the assessment and next plans here.

TCM Progress Note Example

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

Staff completed the referral process by summarizing client's anxiety symptoms and highlighting strengths, including supportive family members. Program ABC indicated client seemed appropriate for their program and provided staff with information on next steps. This staff will contact client to discuss eligibility for program and assist client in preparing to attend Program ABC.

Care Plan

Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

Care Plan is required for all TCM services

This writer provided TCM services to assist the client in accessing these needed services: LIST
The services activities included: LIST (Communication, Coordination, Referral, Monitoring service delivery, Monitoring individual progress)
This writer collaborated with the following person(s) to develop the goals of TCM services: LIST (Client, family, SW, PO, teacher, etc.)

This will pull from previously completed progress notes in SmartCare

Additional TCM Progress Note Examples

INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors):

- Assisted client with researching housing resources.
- Rehearsed phone calls with client to housing agencies/programs.
- Collaborated with client's CWS Social Worker on a plan for a comfortable environment for family visitation.
- Provided client with the information to obtain a discounted bus pass.
- Prompted the client to write appointments down on her calendar in her phone and assisted client with the completion of this task to encourage scheduling/organization.
- This case manager coordinated care with the client's therapist regarding the client's desire work on social anxiety in both individual therapy and individual rehabilitation sessions.

CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

- This Case Manager/Clinician provided TCM services to assist the client in accessing housing resources.

  The TCM service activities included: coordination of care and resource identification.

  This Case Manager/Clinician collaborated with the following individual(s) to develop the goals of TCM services: Client.
- This Therapist provided TCM services to assist the client with visitation plans with her children to target the client's desire for reunification.

  The TCM service activities included: coordination of care.

  This Therapist collaborated with the following individual(s) to develop the goals of TCM services: CWS Social Worker, Client.

Crisis Intervention Service Note Example

Staff can document the Crisis Intervention service in a service note (using the Crisis Intervention Progress Note Template), or document the Crisis Intervention service using the Crisis Assessment document in SmartCare and document the completion of the Crisis Assessment and direct the reader to the Crisis Assessment document dated xx/xx/xxxx on the Crisis Intervention service note. A service note is required for the service to be claimed.

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

Client presented at SLO Outpatient clinic stating he was feeling suicidal. "I just want to go to be with my wife." Client reported feeling depressed and hopeless over the recent loss of his wife.
Describe any SI/HI/SIB or signs of GD.
Describe any risk factors (presence of MI, SUD use/abuse, Hx of violence/self-injury/trauma), recent stressors, past attempts, hopelessness/lack of future orientation, lack of support.
Describe behavioral observations (Client was disheveled in appearance and wearing dirty clothing, which is a significant change from client's usual presentation. Client denied a current plan or intention to harm or kill himself and was receptive to services, as evidenced by his proactively coming to the clinic for help).
Describe protective factors (Client lives with his adult daughter and her partner; client reports his daughter has connected him with a widower support group at Hospice).
Safety Planning (Client was able to identify several coping strategies he can utilize to change is focus and thought patterns, including gardening, watching a sports game, and going for a walk. Client confirmed he has the Central Coast Hotline number saved in his phone and will utilize this resource as needed. Client has not thought of a specific plan or means that he would use to commit suicide and confirmed he does not have guns in his home and agreed to ensure his phone is charged and accessible so he can reach out for support as needed. Client identified his family as his main motivator to remain safe).
Disposition and Next steps:
Steps taken if client is a danger to others (Tarasoff): Phone call to intended victim/send Tarasoff notification letter/phone call to LE/sent Tarasoff worksheet to LE

Care Plan

Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

This will pull from previously completed progress notes in SmartCare - if this is blank include the outcome of the crisis assessment and next plans here.

Plan Development Service Note Example:

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

This writer explored with client the areas of functioning they would like to improve. This writer assisted client in identifying their strengths and social supports. Client shared a desire to increase their social interactions and connections. This writer will meet client at Hope House on 7/11/23 to tour the Wellness Center, look at the calendar of activities, and begin to work on building connections.

Care Plan

Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

This will pull from previously completed progress notes in SmartCare - if this is blank include next steps here.

Individual Therapy Service Note Example:

Psychosocial Rebab Service Note Example:

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

This writer helped develop a list of expenses and income to assist client with creating a monthly budget to ensure they do not run out of money before the end of the month. This writer helped identify necessary vs. discretionary purchases and discussed choices in light of their overall goal. This writer will meet with client next week at the grocery store to support the client in maximizing food purchases.

Care Plan

Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

This will pull from previously completed progress notes in SmartCare - if this is blank include next steps here.

Appendix D – Service Note Templates

TCM/ICC Care Plan Narrative

This writer provided case management services to assist the client in accessing the following needed service(s):

The service activities included:

This writer collaborated with the following person(s) to develop the goal(s) of this case management service:

Identified course of action:

Youth Assessment Update Service Note Template

This clinician met with client/family to complete an assessment of the client's strengths and needs. Please see CANS and PSC assessments dated _____. The client continues to meet access criteria and this clinician recommends the following treatment plan for the next six months: (weekly therapy, case management services as needed, medication support services as directed, etc.) **OR** The client has met their treatment goals and is ready to transition to a lower level of care; this clinician will work with the parent to connect the client with a CenCal provider.

Annual Progress Summary Service Note Template

Current status of presenting problem (describe client's current symptoms and progress in treatment since last review):

Current substance use:

Current challenges/barriers to treatment:

Who are the people involved in the client's life and treatment:

Are Releases of Information in place?

Referrals needed/offered:

Changes in medical status since last review:

Primary care and specialty care providers:

Outreach to health care providers since last review: Annual labs completed?

Is client currently pregnant?

Risk factors/safety plan:

Follow-up plan/next steps:

Discharge Summary Service Note Template

Reason for discharge: (Utilize one: Administrative discharge, Client not appropriate for treatment, Deceased, Discharged against medical advice, Disengaged from services/Non-compliant with treatment, Incarcerated, Involuntary discharge, Moved Out of Area, Never engaged in services, Services no longer needed, Transfer to higher level of care, Transfer to lower level of care, Transferred to a different program)

Summarize treatment and closing discussions/client contact attempts:

Medication Support Service Note Template for Medication Manager

Reason for today's visit:

Services provided: Medication refills, injectable ordered/administered, patient education, care coordination, lab reviews, etc.)

Ordering MN/DO/NP:

Name of pharmacy (for refill verification):

Interval History (describe any relevant events since last visit, symptoms reported, adherence to medication, side effects):

List any new problems identified:

Vital Signs (enter vitals on New Entry Flow Sheet document)

Next Steps: Referrals provided/needed, Follow up appointment

Crisis Intervention Service Note Template

PRESENTING PROBLEM:

FOR THE FOLLOWING, IF YES, PLEASE CHECK & DESCRIBE:

[ ] Suicidal ideation:
- [ ] Evidence of Planning:
- [ ] Access/Means:

[ ] Homicidal ideation:

[ ] Evidence of Planning:

[ ] Access/Means:

[ ] Self Injurious Behavior

[ ] Access/Means:

[ ] Gravely Disabled:

[ ] Other:

RISK FACTORS, IF YES, PLEASE CHECK & DESCRIBE:

[ ] Presence of mental illness:

[ ] Substance Use/Abuse:

[ ] History of prior violence/self-injury/trauma:

[ ] Recent stressors:

[ ] Past attempts:

[ ] Hopelessness/lack of future orientation:

[ ] Lack of support:

[ ] Demographic factors (age, gender, etc.):

BEHAVIORAL OBSERVATIONS (DESCRIBE ANYTHING SIGNIFICANT RE: APPEARANCE, BEHAVIOR, SPEECH, MOOD, ETC.):

PROTECTIVE FACTORS:

SAFETY PLANNING:

DISPOSITION AND NEXT STEPS:

IF CLIENT IS A DANGER TO OTHERS (TARASOFF), DID YOU:

[ ] Phone call to intended victim(s)

[ ] Send Tarasoff notification letter

[ ] Phone call to law enforcement

[ ] Send Tarasoff worksheet to law enforcement

Appendix E – PN Intervention Starters

Acknowledged	Actively Listened	Asked	Assessed	Assisted
Brainstormed	Clarified	Completed	Created	Defined
Developed	Discussed	Encouraged	Engaged	Evaluated
Explained	Explored	Facilitated	Identified	Inquired
Led	Modeled	Normalized	Practiced	Praised
Prompted	Provided	Provided Referral	Redirected	Reframed
Reinforced	Rehearsed	Reminded	Reviewed	Reviewed Progress
Solicited	Suggested	Supported	Taught	Utlized

Appendix F – Standard Abbreviations

AA	Alcoholics Anonymous
AH	Auditory Hallucinations
Acct	Account
ACH	American Care Home
ACTS	Abused Children's Treatment Services
ADHD	Attention-Deficit Hyperactivity/Disorder
Adj	Adjustment
ADL	Activities of Daily Living
AG	Arroyo Grande
AMA	Against Medical Advice
AOT	Assisted Outpatient Treatment
Appt	Appointment
APS	Adult Protective Services
ASA	Acetylsalicylic Acid (Aspirin)
ASAP	As Soon As Possible
ASH	Atascadero State Hospital
Assmt	Assessment
ATP	Adult Transitional Program
Avg	Average
AWOL	Absent Without Leave
B&C	Board and Care
BA	Blood Alcohol
Beh	Behavioral
BID	Two Times Per Day
B/f	Boyfriend
B/o	Because Of
B/P	Blood Pressure
BAL	Blood Alcohol Level
Bec	Because
BHTC	Behavioral Health Treatment Court
BIB	Brought In By
Bldg	Building
BPD	Bipolar Disorder
BPM	Beats Per Minute
Bro	Brother
C&S	Culture and Sensitivity
Ca	Calcium
CABG	Coronary Artery Bypass Graft
CAPD	Chronic Ambulatory Peritoneal Dialysis
CAT	Community Action Team
Cath	Catheter or Catheterization
Cauc	Caucasian
CBT	Cognitive Behavioral Therapy
Cert	Certification
CHC	Community Health Center
Cigs	Cigarettes
Clt	Client
CM	Case Manager
CMC	California Men's Colony
Co	County
COE	County Office of Education
Cond	Condition
Coord	Coordination
Corresp	Correspondence
CPR	Cardiopulmonary Resuscitation
C-Section	Caesarean Section
CWS	Child Welfare Services
Cx	Cancel
CXR	Chest X-Ray
D&A	Drug and Alcohol
DOE	Date of Entry
D/O	Disorder
D/S	Discharge Summary
D/T	Due To
DAS	Drug and Alcohol Services
Dbl	Double
DBT	Dialectical Behavioral Therapy
FSA	Family Service Agency
FSP	Full-Service Partnership
DI	Delusional Ideation
Diff	Differential (on CBC request)
DKA	Diabetic Ketoacidosis
DOB	Date of Birth
DSS	Department of Social Services
DT	Day Treatment
DUI	Driving Under the Influence
DV	Domestic Violence
Dx	Diagnosis
ED	Emergency Department
EMG	Electromyogram
EMT	Emergency Medical Technician
ER	Emergency Room
ESRD	End Stage Renal Disease
Est	Estimate, estimation
Et al	And Others
ETOH	Alcohol
Eval	Evaluation
EW	Eligibility Worker
F Hx	Family History
F of O	Family of Origin
F/U	Follow up
Fa	Father

Fam	Family
FCN	Family Care Network
Fn	Functioning
FNP	Family Nurse Practitioner
FoBro	Foster Brother
FoFa	Foster Family
FoMo	Foster Mother
FoSis	Foster Sister
FPC	Family Practice Clinic
FRS	Forensic Re-Entry Program
FTS	Failure to Show
G/f	Girlfriend
G/u	Grew up
GAF	Global Assessment Functioning
GB	Grover Beach
Gc	Gonorrhea
GD	Grave Disability
GGF	Growing Grounds Farm
GP	General Practitioner
GR	General Relief
Grp	Group
H&P	History and Physical
H/o	History of
H2O2	Hydrogen Peroxide
HA, H/A	Headache
Halluc	Hallucination
HBP	High Blood Pressure
HCTZ	Hydrochlorothiazide
HEENT	head, ears, eyes, nose, and throat
HI/SI	Homicidal ideation/Suicidal ideation
Hisp	Hispanic
HIV	Human Immunodeficiency Virus
HPI	History of Present Illness
HR	Heart rate
Hx	History
Hyper	Hyperactive
I	Intern
I&D	Incision and Drainage
I&O	Intake and Output
IDDM	Insulin Dependent Diabetes Mellitus
IEP	Individualized Education Plan
In	Inch
Incl	Include(s)
Incr	Increase
Ind	Individual
Int Med	Internal Medicine
IRB	Institutional Review Board
Irreg	Irregular
JSD	Justice Services Division
KCl	Potassium Chloride
LT mem	Long-term Memory
L/M	Left Message
Lac	Laceration
LCSW	Licensed Clinical Social Worker
LE	Law Enforcement
Li	Lithium
LiCo3	Lithium Carbonate
LMFT	Licensed Marriage and Family Therapist
LMUSD	Lucia Mar Unified School District
LO	Los Osos
LOB	Loss of Balance
LOP	Latino Outreach Program
LOS	Length of Stay
LPCC	Licensed Professional Clinical Counselor
LPHA	Licensed Practitioner of the Healing Arts
LPS	Lanterman-Petris-Short
LPT	Licensed Psychiatric Technician
LTC	Long-term Care
LVN	Licensed Vocational Nurse
MA/PT	Master's (of Art or Science), psych tech
MAOI	Monoamine Oxidase Inhibitor
MAT	Medication for Addiction Treatment
Max	Maximum
MB	Morro Bay
M/C	Medi-Cal
MCP	Managed Care Plan
Med/Surg	Medical/surgical
Med Eval	Medical Evaluation with MD
Med Hx	Medical History
Meds	Medicine, medication
Meth	Methamphetamine
Mgt	Management
MH	Mental Health
MHP	Mental Health Plan
MHS	Mental Health Services
MI	Myocardial Infarction
Min	Minute
Misc	Miscellaneous
Mo	Month
Mod	Moderate
MR	Medical Record
MS	Multiple Sclerosis
MSE	Mental Status Exam
Msg	Message
Mtg	Meeting
MVP	Mitral Valve Prolapse

NA	Narcotics Anonymous
N/A	Not Applicable
NAD	No Acute Distress
NAR	No Adverse Reaction
Narc	Narcotics
NC, N/C	No Charge
NC MH	North County Mental Health
NIDDM	Non-Insulin Dependent Diabetes Mellitus
NKDA	No Known Drug Allergies
NOS	Not Otherwise Specified
NP	Nurse Practitioner
NSAID	Non-Steroidal Anti-Inflammatory Drug
NSR	Normal Sinus Rhythm
NTG	Nitroglycerin
NWP	Network Provider
OA	Overeaters Anonymous
Occ	Occasional
OCD	Obsessive Compulsive Disorder
OD	Overdose
OOB	Out of Bed
OP	Outpatient
Op	Operation
Oriented X3	Oriented by person, place, date
OS	By mouth
OT	Occupational Therapy
OTC	Over the Counter
OUD	Opioid Use Disorder
P&O	Prevention and Outreach
P/C	Phone Call
PCN	Penicillin
PD	Police Department
PDA	Patent Ductus Arteriosus
PDD	Pervasive Developmental Disorder
PDR	Physician's Desk Reference
PG	Public Guardian
PH	Hydrogen Ion Concentration
Pharm	Pharmacy
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHN	Public Health Nurse
PI	Paranoid Ideation
PKU	Phenylketonuria
PMS	Premenstrual Syndrome
PO	Probation Officer
po	By Mouth
Pre	Before
Preop	Preoperatively
Prep	Preparation
PRN	As needed
Prog	Program
Pro-time	Prothrombin time
Psych	Psychiatric
PT	Physical Therapy
Pt	Patient
PTSD	Post-Traumatic Stress Disorder
PTT	Partial Thromboplastin Time
QAM	In the morning
QD	Daily
QHS	At hour of sleep
QID	Four times per day
QPM	In the afternoon
Qt	Quart
R/O	Rule Out
R/R	Rate and Rhythm (speech)
RBC	Red Blood Cell
Re	Recheck, Regarding
Rec	Recreation
Reg	Regular
Rehab	Rehabilitation
Rel	Relationship
Res Tx	Residential Treatment
Ret'd	Returned
Rm	Room
RN	Registered Nurse
RTC	Return to Clinic
Rx	Prescription
S/Sx	Signs/Symptoms
SA	Suicide Attempt
SAFE	Systems Affirming Family Empowerment
SC	Subcutaneous
SC MH	South County Mental Health
Sched	Schedule
Schiz	Schizophrenia
SDI	State Disability Insurance
SE	Side Effect
Sec	Second, Secondary
SED	Serious Emotional Disturbance
SI	Suicidal Ideaion
SIDS	Sudden Infant Death Syndrome
Sis	Sister
SLCUSD	San Luis Coastal Unified School District
SLO	San Luis Obispo
SLOCO Prob	SLO County Probation Department
SLOPD	SLO Police Department
SLOSD	SLO Sheriff's Department
Sm	Small

SMHS	Specialty Mental Health Services
SNF	Skilled Nursing Facility
SO	Significant Other
SOB	Shortness of Breath
SOC	Share of Cost
Soc	Socialization
Soc Serv	Social Services
Sol	Solution
Sp	Spelling
Spont	Spontaneous
SSA	Social Security Administration
STD	Sexually Transmitted Disease
Sub	Substitute
Sup Grp	Support Group
Supp	Suppository
Surg	Surgeon, surgery
Svs	Services
SVT	Supra Ventricular Tachycardia
S/D	Short-Doyle
S/P	Status Post
S/R	Seclusion/Restraints
SW	Social Worker
Sx	Symptom
TO	Telephone Order
T/C	Telephone Call
TAY	Transitional Aged Youth
TBI	Traumatic Brain Injury
Tbsp	Tablespoon
TCCH	Twin Cities Community Hospital
TCRC	Tri-Counties Regional Center
TD	Tardive Dyskinesia
Temp	Temperature
TFT's	Thyroid Function Tests
TH	Tactile Hallucination
THC	Marijuana
THPP	Transitional Housing Placement Program
TMHA	Transitions Mental Health Association
TMJ	Temporomandibular Joint Disorder
Tox	Toxicology
TPN	Total Parenteral Nutrition
Trans	Transfer, Transdermal
TSH	Thyroid-Stimulating Hormone
Tx	Treatment, Therapy
Unk	Unknown
UR	Utilization Review
UTI	Urinary Tract Infection
V Tach	Ventricular Tachycardia
W/D, Wd	Withdrawn
W/O	Without
W/U	Write Up
Wk	Week
WNL	Within Normal Limits
Work Comp	Workers' Compensation
Y/O	Year(s) old
Yr	Year
YS	Youth Services
YTP	Youth Treatment Program
Tx	Therapy

Appendix G – Progress Note Service Indicators

Service indicators on Progress Notes

Status – Indicates the status of the service using a drop-down menu

Program – Lists the client's current program assignments to indicate which program the service was provided in. If you do not see your program listed here reach out to a HIT for help with the client's program enrollment.

Procedure – Select the Service Name that best describes the service you provided

Location – Select the location of the client at the time of receiving the service

Mode of Delivery – Select the option from drop-down menu

Cancel Reason – This field becomes active if you select "Cancel" as the Status of the services, select from the drop-down menu

Evidenced Based Practice – If you have been trained and utilized an evidenced based practice, select from the drop-down menu

Transportation Services – Enter if transportation services were provided to the client, select from the drop-down menu – This fields defaults to "No"

Start Date – Enter the start date of the service, this will automatically fill if the service was scheduled on the SmartCare calendar

Start Time – Enter the start date of the service, this will automatically fill if the service was scheduled on the SmartCare calendar

Travel Time – If you traveled to provide the service enter the total travel time here

Documentation Time – Enter the time you spend documenting the service, if this time is not captured in the service time/if you utilized concurrent documentation

Service Time – This is where you enter the total service time, regardless of the mode of delivery

Attending – Do not use this field

Referring – Do not use this field

Emergency Indicator – Select "No," unless the service is a crisis intervention

Interpreter Services Needed – Select the box if an interpreter was needed, if an interpreter was needed, complete the Interpreter Service Custom Fields

Appendix H – PN Time Entry Guidance

Service Time	•Time Specalist/Clinician spent providing a service. •Enter total service time in Service Time box. •Includes all modes of service delivery: face-to-face, telephone (telehealth audio only), video conferencing (telehealth video + audio), and written.
Documentation Time	•Time Specialist/Clinician spent writing the Progress Note. •Enter total documentation time in Documenation Time box. •Documentation time is not billed as part of the service, but it must be entered so that data about staff time/activities can be studied over time by State. •For Group Services, the Documentation Time box is for each individual participant. •Note: If concurrent or collaborative documentation was completed during the service, documetnation time must not be added.
Travel Time	•Time Specialist/Clinician spent traveling to provide a service. •Enter total travel time in Travel Time box. •Travel time can be one way or round trip. •Travel time is time spent traveling from a Medi-Cal certfied site to the service location (ex. client home, school, another office such as DSS). •Travel time does not include traveling from one Behavioral Health site to another. •Travel time is not billed as part of the service, but it must be entered so that data about staff time/activities can be studied over time.
Tranportation Time (DMC-ODS Services Only)	•Time Specialist/Clinician spent transporting a client to link them to physical healthcare, mental health care, medically necessary treatment, or to other ancillary services is a Case Management intervention. •Must be part of a TCM/ICC service only. No other DMC-ODS procedures/services allow for transportation to be billed as part of the service time. •Transportion time is service time. •Progress note must include statement(S) about transportation in the Progress Note narrative intervention section.

Appendix I – Urgent Service Follow-Up

Procedure for Post PHF/Hospital/CSU/ED/MHET/Jail follow up for a client not currently receiving SMHS

Front Office Staff Duties:
When a client arrives for a post-urgent service appointment, the Front Office staff will complete all standard intake paperwork with client per existing procedures.

Provider Duties:
This initial appointment is an opportunity to **engage the client and the family into treatment and to assess for current risk factors and safety concerns**. The client will need to be scheduled for a CalAIM Assessment, however other treatment services may be provided before the assessment is completed to meet the client's current needs. The service provided at a post hospitalization appointment can include: TCM, Psychosocial Rehabilitation, Individual Therapy, or Crisis Intervention, depending on the client's needs.

Documentation Workflow

Did client keep first appointment?

No

Scheduled Provider:
- Call Client
- Mail letter
- Inform referral source/other providers, as appropriate

Yes

Scheduled Provider:
- Provide service
- Schedule intake assessment
- Schedule psychiatric evaluation, if needed
- Complete Service Note

Did client keep scheduled assessment?

No

Scheduled Provider:
- Call client, reschedule if possible
- Notify clinic staff

Yes

Scheduled Provider:
- Complete assessment
- Document recommendations on CalAIM Assessment
- Complete Service Note

Clinic Staff
- Call client, engage in treatment
- Reschedule assessment
- Keep MD/NP appointment scheduled/schedule as needed
- Follow No Shows, Outreach, and Client Engagement Attempts/Efforts P&P

Appendix J – Social Determinants of Health

Description	ICD 10 Code	SNOMED Code
Academic or Educational Problem	Z55.9	4506002
Unemployment Unspecified	Z56.0	73438004
Other Problem Related to Employment	Z56.89	75148009
Homelessness	Z59.00	32911000
Inadequate Housing	Z59.1	105528000
Discord with Neighbor, Lodger, or Landlord	Z59.2	287991000119107
Problem Related to Living in a Residential Institution	Z59.3	15929301000119104
Lack of Adequate Food or Safe Drinking Water	Z59.41	1078229009
Extreme Poverty	Z59.5	160932005
Low Income	Z59.6	424860001
Insufficient Social Insurance or Welfare Support	Z59.7	365558004
Unspecified Housing or Economic Problem	Z59.9	160932005
Phase of Life Problem	Z60.0	9431000
Problem Related to Living Alone	Z60.2	620981000124101
Acculturation Difficulty	Z60.3	105413002
Social Exclusion or Rejection	Z60.4	77096008
Target of (Perceived) Adverse Discrimination or Persecution	Z60.5	620961000124106
Unspecified Problem Related to Social Environment	Z60.9	161152002
Child in Welfare Custody	Z62.21	288171000119109
Personal History (past history) of Physical Abuse in Childhood	Z62.81	288391000119107
Parent-Child Relational Problem	Z62.82	52184009
Personal History (past history) of Sexual Abuse in Childhood	Z62.81	288391000119107
Personal History (past history) of Psychological Abuse in Childhood	Z62.811	288401000119109
Personal History (past history) of Neglect in Childhood	Z62.812	288381000119109
Child Affected by Parental Relationship Distress	Z62.898	14345008
Relationship Distress with Spouse or Intimate Partner	Z63.0	1041000119100
Uncomplicated Bereavement	Z63.4	3763000
Disruption of Family by Separation or Divorce	Z63.5	28332004
High Expressed Emotional Level Within Family	Z63.8	166491000119100
Problems Related to Unwanted Pregnancy	Z64.0	151901000119101
Problems Related to Multiparity	Z64.1	288571000119100
Discord with Social Service Provider, Including Probation Officer, Case Manager, or Social Services Worker	Z64.4	Social Worker 105519001
		Probation Officer 105521006
		Counselor 105520007
Conviction in Civil or Criminal Proceedings without Imprisonment	Z65.0	224340002
Imprisonment or Other Incarceration	Z65.1	45361006

Appendix K – Medication Manager Service Note Examples

Mental Health Medication Example Note #1

Reason for today's visit: Medication Training & Support for current/continued medications to treat OCD.

Services provided (medication refills, injectable ordered/administered, patient education, care coordination, lab reviews, etc): Medication refills, patient education, care coordination.

Ordering MN/DO/NP: Dr. Puri

Name of pharmacy (for refill verification): Vons Pharmacy, Grover Beach

Interval History (describe any relevant events since last visit, symptoms reported, adherence to medication, side effects): Client has been taking Fluoxetine 40mg to treat OCD D/O for 6 months. Client reported a reduction in obsessive thoughts and compulsive behaviors since the last medication support visit (2 months ago). Client estimated that she is engaging in checking behaviors 5 times a week for approximately 10 minutes, which is a large reduction since starting medications where she was engaging in checking behaviors 7-days a week for up to 3 hours a day. Client reported that she was not concerned about any side effects at this time and reported she is taking her medication daily, although sometimes forgets to take her medication when she sleeps in. LPT provided education about different strategies/reminders to take medications consistently (ex. alert/reminder on telephone).

List any new problems identified: Client reported that she would like to have even more control over obsessive/compulsive symptoms and requested that the dosage of Fluoxetine be increased. This LPT sent a message request to MD listed above with the client's request to increase Fluoxetine dosage.

Vital Signs (enter vitals on New Entry Flow Sheet document): See New Entry Flow Sheet dated 10/6/2023 for vitals.

Next Steps (Referrals provided/needed, Follow Up appointment): Client was scheduled for another medication support follow up session for 4-weeks on 11/6/2023. This LPT will contact client with the outcome of the MD's response about increasing the dosage of Fluoxetine. Client has two weeks of medication supply currently.

Mental Health Medication Example Note #2

Reason for today's visit: Client called the clinic because she was out of her medication Lamotrigine. Client missed her medication support visit with Dr. Lampe last week and has run out of her medication.

Services provided (medication refills, injectable ordered/administered, patient education, care coordination, lab reviews, etc): Medication refills, patient education, care coordination.

Ordering MN/DO/NP: Dr. Lampe

Name of pharmacy (for refill verification): CVS, San Luis Obispo, Marigold Shopping Center

Interval History (describe any relevant events since last visit, symptoms reported, adherence to medication, side effects): Client has been taking 100mg of Lamotrigine for 3 months to treat her bipolar disorder. This LPT coordinated with the prescriber, and the client was prescribed two weeks of medication until her rescheduled medication support appointment with Dr. Lampe on 10/15/2023. This LPT informed Client of this refill being completed, and the importance of the client following through with attending the next medication appointment with the doctor. Client reported no barriers for being able to attend the next appointment and no current concerns about side effects. LPT reviewed that Lamotrigine is a high-risk medication that can cause a rash that is potentially life threatening. LPT reminded the client to self-monitor for a rash and to immediately contact the clinic or go to the ER if a rash develops. Client denied having any current rash and indicated that she understood the instructions.

List any new problems identified: No new problems identified. The client has missed 1 appointment with the MD on 9/30/2023.

Vital Signs (enter vitals on New Entry Flow Sheet document): NA because service took place by telephone.

Next Steps (Referrals provided/needed, Follow Up appointment): Client was rescheduled medication support appointment with Dr. Lampe on 10/15/2023.

Mental Health Injection Medication Example Note #3

Reason for today's visit: Medication Training & Support visit for injection medication.

Services provided (medication refills, injectable ordered/administered, patient education, care coordination, lab reviews, etc): Prior to administering the injection, LPT reviewed the risks, benefits, and alternatives to the medication with the client, and the client provided verbal

consent for the injection. Patient education provided for information about injection/injection site. Injection medication administered - Invega Sustenna 234mg IM into right deltoid without incident. Vivitrol/Naltrexone, 380mg). Injection logged onto the Long Acting Injection Flow Sheet. Medication refill request sent to MD for next month.

Ordering MN/DO/NP: Dr. Penepacker

Name of pharmacy (for refill verification): Genoa Pharmacy, San Luis Obispo

Interval History (describe any relevant events since last visit, symptoms reported, adherence to medication, side effects): Client has been taking Invega Sustenna for 6 months to treat Schizophrenia. Client reported he likes taking his medication via injection and wants to continue with this plan. LPT reviewed injection site information with Client and administered the medication.

List any new problems identified: Client reported that his hours were reduced at work and that this has caused some financial stress, but that he has been told his hours will increase next month.

Vital Signs (enter vitals on New Entry Flow Sheet document): See New Entry Flow Sheet dated 10/16/2023 for vitals.

Next Steps (Referrals provided/needed, Follow Up appointment): Client was scheduled for another medication support follow up session for 28-days scheduled on 11/10/2023.

Case Management Service Note Template & Examples for Medication Managers

INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors):

- As this was the client's first medication management appointment, this LPT introduced self to client to build rapport.
- Provided client with information on mental health services, programs and resources, including support groups.
- To complete the Treatment Authorization Request (TAR), coordinated with pharmacist and client's insurance to get psychotropic medication(s)/MAT medication(s) approved.
- Coordinated with the laboratory regarding the diagnosis code.
- Contacted the laboratory to obtain the client's recent lab results. Once the lab results were received and scanned into the record, notified MD that labs needed to be reviewed.

- Completed referral for the client to see their Primary Care Physician (PCP) due to the client's complaints of xyz.
- Discussed the client's desire to obtain employment and completed a referral to an employment agency.
- Reviewed and discussed client's progress in managing his mental health symptoms with medication and therapeutic services.
- Assisted client with researching housing resources.
- Rehearsed phone calls with client to housing agencies/programs.
- Provided client with the information to obtain a discounted bus pass.
- Prompted the client to write appointments down on her calendar in her phone and assisted client with the completion of this task to encourage scheduling/organization.
- For this Post-PHF/Post-Jail discharge case management appointment, this LPT met with the client to discuss the client's needs for connection to SMHS and SUD treatment services and community resources. Provided client with a list of resources for food programs as client indicated current difficulty affording groceries. Made plan with client to attend the next DAS Walk-In hours at DAS SLO on 10/16/2023. Reviewed plan already set in place for client to attend a MH Assessment on 10/17/2023 for ongoing SMHS services.

CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

- This LPT provided TCM services to introduce the client to mental health services available through the clinic and through other providers (TMHA).

  The TCM service activities included: coordination of care and resource identification.

  This LPT collaborated with the following individual(s) to develop the goals of TCM services: Client.
- This Medication Manager provided TCM services to assist the client with obtaining the prescribed medication to address his/her/their mental health condition.

  The TCM service activities included: coordination of care.

  This Therapist collaborated with the following individual(s) to develop the goals of TCM

services: Pharmacy, Prescriber, Client.

- This Medication Manager provided TCM services to assist the client with obtaining services from their PCP.

  The TCM service activities included: coordination of care.

  This Therapist collaborated with the following individual(s) to develop the goals of TCM services: Client, PCP Office.

Mental Health Annual Progress Summary Service Note Template & Example for Medication Managers

Current status of presenting problem (describe client's current symptoms and progress in treatment since last review): The client is a 29-year old, male, who is receiving SMHS for Schizoaffective Disorder. The client has been in services for one year. The client's symptoms are well controlled with medication. The client entered SMHS as a referral from the PHF. He was hospitalized two times 11-months ago, but has not been hospitalized since.

Current substance use: Client reports that he consumes alcohol on the weekends, approximately 2 drinks/2 days week. Client reports that he occasionally uses marijuana, approximately 1 time per month. There has been no observation or collateral information to indicate that the client is using substances more than reported.

Current challenges/barriers to treatment: Client frequently misses appointments because he does not have reliable transportation and he feels uncomfortable using public transportation. Client attends appointments when he can get a ride from a friend/family member. Telehealth appointments are provided as appropriate to help address this barrier. The client is dependent on family for financial resources, transportation, and housing.

Who are the people involved in the client's life and treatment: The client lives with his mother. She was involved in his treatment when he was a minor and she continues to be supportive by offering transportation to appointments when she can.

Are Releases of Information in place? Releases of information are in place with PCP and TMHA and are valid until the end of treatment.

Referrals needed/offered: Client has been referred this week to CenCal for assistance with transportation to/from his mental health appointments. The client would like to work towards greater independence. The client has been referred to TMHA for their housing program and work program.

Changes in medical status since last review: No changes.

Primary care and specialty care providers: The client's PCP is Dr. Cook at CHC Atascadero.

Outreach to health care providers since last review: Message left for PCP on xx/xx/xxxx because of client's elevated glucose level.

Annual labs completed? Yes. Glucose was moderately elevated.

Is client currently pregnant? NA

Risk factors/safety plan: Client has a safety plan in place following his PHF admission 11 months ago. Safety plan was recently updated to review coping skills and crisis contacts.

Follow-up plan/next steps: This LPT will continue to pursue coordination with PCP regarding glucose levels. This LPT will continue to work with the client and client's therapist on referrals to TMHA's housing and work programs.

Appendix L – Transition of Care

Transition of Care Tool for Medi-Cal Mental Health Services

REFERRING PLAN INFORMATION

[X] **County Mental Health Plan** [ ] **Managed Care Network Plan**

Submitting Plan: San Luis Obispo

Plan Contact Name: Getten, Amanda Margaret **Title:** MFT Marriage and Family Therapist

Phone: **Email:** agetten@co.slo.ca.us **Address:** 2180 Johnson Ave

City: San Luis Obispo **State:** California **Zip:** 93401

BENEFICIARY INFORMATION

Beneficiary's Name:	**Beneficiary's Preferred Name:**	**Date of Birth:**
Mh Client, Fictional A		1/1/1988

[X] **Beneficiary or Legal Representative in Agreement with Referral or Transition of Care**

Gender Identity: [ ] Male [X] Female [ ] Transgender Male [ ] Transgender Female [ ] Non-binary [ ] _____

Pronouns [ ] He/Him [X] She/Her [ ] They/Them [ ] _____

Address: 11 FICTION WAY **City:** SAN LUIS OBISPO **Zip:** 93401

Phone: 8055555555 **Email:** Not Collected.

Caregiver/Guardian: Not Collected. **Phone:** Not Collected.

Medi-Cal# (CIN)/SSN: 555000001 **Race:** **Ethnicity:**

Behavioral Health Diagnosis or Diagnoses, if known:

Recent Diagnosis Document Attached to End of Form.

Supporting Clinical Documents Included:

No Recent CalAIM Assessment.

No Recent CANS Assessment.

Cultural and Linguistic Requests:

Primary Language: Spanish.

Client does NOT speak English. Additional Information: Include information to assist CenCal in identifying a provider who may be a good match for the client.

Current Presenting Symptoms/Behaviors (including substance use if appropriate):

See attached document.
Additional Information: Describe the client's symptoms, impairments, and needs that will be the focus of treatment.

[X] Additional Pages Attached

Current Environmental Factors (including changes in caregiver relationships, living environment, and educational considerations):

Describe any changes in the client's relationships, living, school, and/or work environments since the client's last assessment. If the last assessment document is up to date indicate there have been no changes in these factors since the (reference last assessment name and date).

☐ Additional Pages Attached

Brief Behavioral Health History (including psychosocial stressors or traumatic experiences):

Describe the services the client has received, the focus of treatment, the client's responsiveness to services, and discussions with client/family about this transition of care.

☐ Additional Pages Attached

Brief Medical History:

Additional Information: Describe any changes in the client's medical needs since the client's last assessment. If the last assessment document is up to date indicate there have been no changes in the client's medical needs since the (reference last assessment name and date).

☐ Additional Pages Attached

Current Medications/Dosage:

See attached document.

☒ Medication List Attached

Primary Care Provider/Current Care Team: PCP NAME: N/A- Not Collected. **Phone:** N/A

See attached Tx Team document.

SERVICES REQUESTED:

☒ **Transition Care to:** CenCal

☐ **Adding Service(s) from:**

What service(s) is the beneficiary being referred for?

Indicate the services the client is being referred for - therapy and/or psychiatric services

TRANSITION OF CARE OR SERVICE REFERRAL DESTINATION

☒ **Managed Care Plan:** **CenCal Health**

Managed Care Plan Contact Information

Fax: 805-681-3019 **Phone:** 805-685-9525 **Toll Free:** 800-421-2560 **TTY:** 800-977-2273 TTY

☐ **County Mental Health Plan:**

County Mental Health Plan Contact Information

Fax: **Phone:** **Toll Free:** **TTY:**

Behavioral Health Diagnosis or Diagnoses, if known:

CalMHSA - San Luis Obispo County

Diagnosis Document

Client Name:	Mh Client, Fictional A	**Client ID:**	400001
DOB:	01/01/1988	**Effective Date:**	07/01/2023
Program:	SLO Clinic MD Youth (1608)		

Diagnosis

Alcohol use disorder, Severe

DSM5/ICD10	F10.20	**SNOMED**	
ICD/ DSM Description	Alcohol use disorder, Severe		
Remission		**Specifier**	
Type	Primary		
Source		**Severity**	
Order	1		
Rule Out	No	**Billable**	Yes

Paranoid schizophrenia

DSM5/ICD10	F20.0	**SNOMED**	
ICD/ DSM Description	Paranoid schizophrenia		
Remission		**Specifier**	
Type	Additional		
Source		**Severity**	
Order	2		
Rule Out	No	**Billable**	Yes

Additional Information

Screening Tools Used

Other General Medical Conditions

Psychosocial, Environmental, and Other Factors

Comments

Level of Functioning Score

GAF Score

WHODAS Score

CAFAS Score

Staff:	Wyatt Elliott Ryan	**Signature Date:**	07/01/2023

Current Symptoms and Behaviors:

Current Presenting Symptoms/Behaviors:

ICD10 Description	ICD10 Code	Start Date
Other problems related to social environment	Z60.8	5/14/2023
Depression, unspecified	F32.A	6/29/2023
Sheltered homelessness	Z59.01	7/1/2023
Parent-child relational problem	Z62.820	7/21/2023

Current Medications/Dosage:

Name: Mh Client, Fictional A DOB: 1/1/1988 Sex: M

Diagnosis

ICD 10 Code: F41.1 - Generalized anxiety disorder

Medication List

Medication	Date Initiated	Instructions	Rx Start	Rx End	Prescriber
Prozac	7/5/2023	10mg, cap, Oral 1 each Annually	7/5/2023	7/5/2023	Ilano, Maria Daisy MD Medical Doctor

TEST TEST TEST

Primary Care Provider/Current Care Team:

External Primary Care Provider: **Client does not have External Primary Care Provider.**

Current Treatment Team:

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Statler, Cami		TMHA MHSA Adult FSP (3210)		
Moss, Fred		SLO Clinic MD Youth (1608)		
Fraer, Michelle		TMHA Residential CM - Empleo (3240)		
Miller, Triesha		SMW MHSA CSS MHET Crsis Hold (3101)		
Rogez, Jennfier		CDC Child Devlpmnt Center MHS (3801)		
Boaz Alvarez, Meghan Kathleen		TMHA Adult Referral (3217)	mboazalvarez@t-mha.org	
Remy, Elaine Summers		TMHA Adult Referral (3217)		
Lofgren, Ly-Lan Marie Vo		TMHA MHSA Adult HOT Engagement (3248)		
Buckley, Coleen Winona		SMW MHSA CSS MHET Crsis Divert (3102)		
Brance, Janette L		WCS MHSA Older Adult FSP (3301)		
Gabriel, Mary Katherine		SLO Clinic Intake Adult (1401)	mgabriel@co.slo.ca.us	
Gabriel, Mary Katherine		SMW MHSA CSS MHET Crsis Hold (3101)	mgabriel@co.slo.ca.us	
Gabriel, Mary Katherine		SMW MHSA CSS MHET Crsis Divert (3102)	mgabriel@co.slo.ca.us	
Gabriel, Mary Katherine		SLO Generic Clients Only Youth (1691)	mgabriel@co.slo.ca.us	
Gabriel, Mary Katherine		SLO Martha's Pl Generic Client (1812)	mgabriel@co.slo.ca.us	
Gabriel, Mary Katherine		NCA Generic Clients Only Youth (2096)	mgabriel@co.slo.ca.us	
Gabriel, Mary Katherine		TMHA Generic Client Only Youth (3261)	mgabriel@co.slo.ca.us	
McGuire, Kathy		ADM MAA Services (2601)	kmcguire@co.slo.ca.us	
Koenig, Rachael		SLO Clinic Adult (1402)	rkoenig@co.slo.ca.us	
Koenig, Rachael		SLO Clinic Youth (1602)	rkoenig@co.slo.ca.us	
Koenig, Rachael		MC MHSA CSS Crisis Interventn (3001)	rkoenig@co.slo.ca.us	
Koenig, Rachael		TMHA Residential CM (3201)	rkoenig@co.slo.ca.us	
Koenig, Rachael		SCA Generic Clients Only Youth (2299)	rkoenig@co.slo.ca.us	
Atwell, Brian Rick		SLO PHF Adult (1201)	batwell@co.slo.ca.us	
Ryan, Wyatt Elliott		NCA Clinic Youth (2004)		
Ryan, Wyatt Elliott		SCA Arroyo Grande High School (2254)		
Heintz, Molly		NCA Abused Children Trtmnt Srv (2060)	mheintz@co.slo.ca.us	
Heintz, Molly		SLO Generic Clients Only Adult (1487)	mheintz@co.slo.ca.us	
Goodman, Ramona		SLO Clinic Med Mgr Adult (1404)	rgoodman@co.slo.ca.us	
Drews, Nicholas		SLO Clinic Youth (1602)	ndrews@co.slo.ca.us	
Andrews-Wise, Lesley		SCA Clinic Youth (2204)		
Green, Chandler	Family/Friend	FCN Therapeutic Foster Care (3469)		
Greenberg, Erin	Family/Friend	FCN Therapeutic Foster Care (3469)	egreenberg@fcni.org	

Current Treatment Team:

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Sommers, Allison Gayle		SLO MHSA Martha's Place (1806)	ASommers@co.slo.ca.us	8054616076

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Hoffman, Christine Marie		SCA MHSA Youth Intake (2275)	cmhoffman@co.slo.ca.us	

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Mc Spadden Tarver, Rachel Diane		SLO MHSA Martha's Place (1806)	rtarver@co.slo.ca.us	8057814295

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Kindem, Anneliese Lorraine D		SLO Clinic Youth (1602)	akindem@co.slo.ca.us	

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Sommers, Allison Gayle		SLO Clinic Youth ERSESS (1603)	ASommers@co.slo.ca.us	8054616076

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Abdul Cader, Nisha		SLO Martha's Place MD (1804)	nabdulcader@co.slo.ca.us	8057814948

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Abdul Cader, Nisha		SLO Martha's Place MD (1804)	nabdulcader@co.slo.ca.us	8057814948
Mc Spadden Tarver, Rachel Diane		SLO MHSA Martha's Place (1806)	rtarver@co.slo.ca.us	8057814295

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Martinez, Jennifer Ramirez		NCA MHSA Case Mgr Youth (2089)	jmartinezramirez@co.slo.ca.us	

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Getten, Amanda Margaret		SLO MC Authorizations Adult (1001)	agetten@co.slo.ca.us	

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Mc Spadden Tarver, Rachel Diane		SLO MHSA Martha's Place (1806)	rtarver@co.slo.ca.us	8057814295

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Atencio, Danielle Sophia		GB Drug Testing Moderate Level (52G3)		

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Myers, Sean		DAS SLO Adult MAT Vivitrol 1.0 (5480)	smyers@co.slo.ca.us	8057814844
Cearley, Jana		SLO (2180) JAG Med Mgr Adult (1391)	JCearley@co.slo.ca.us	8057814334
Benavidez, Anthony		SA Sober Living Restor Partner (7429)	abenavidez@co.slo.ca.us	8057814853
Benavidez, Anthony		SLO (2180) JAG Case Mgr Adult (1392)	abenavidez@co.slo.ca.us	8057814853
Masullo, Maria		SLO (2180) MHSA Adult BHTC (1341)	mmasullo@co.slo.ca.us	8057814282
Vierra, Allie Noelle		DAS SLO Drug Testing Only (5407)	avierra@co.slo.ca.us	
Vierra, Allie Noelle		SLO (2180) JAG Pgm Adult (1390)	avierra@co.slo.ca.us	

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Kindem, Anneliese Lorraine D		SLO Clinic Youth (1602)	akindem@co.slo.ca.us	

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Garcia-Noriega, Alyssa	Behavioral Health Worker	FCN ICC/IHBS (3464)	agarcianoriega@fcni.org	

Current Treatment Team:

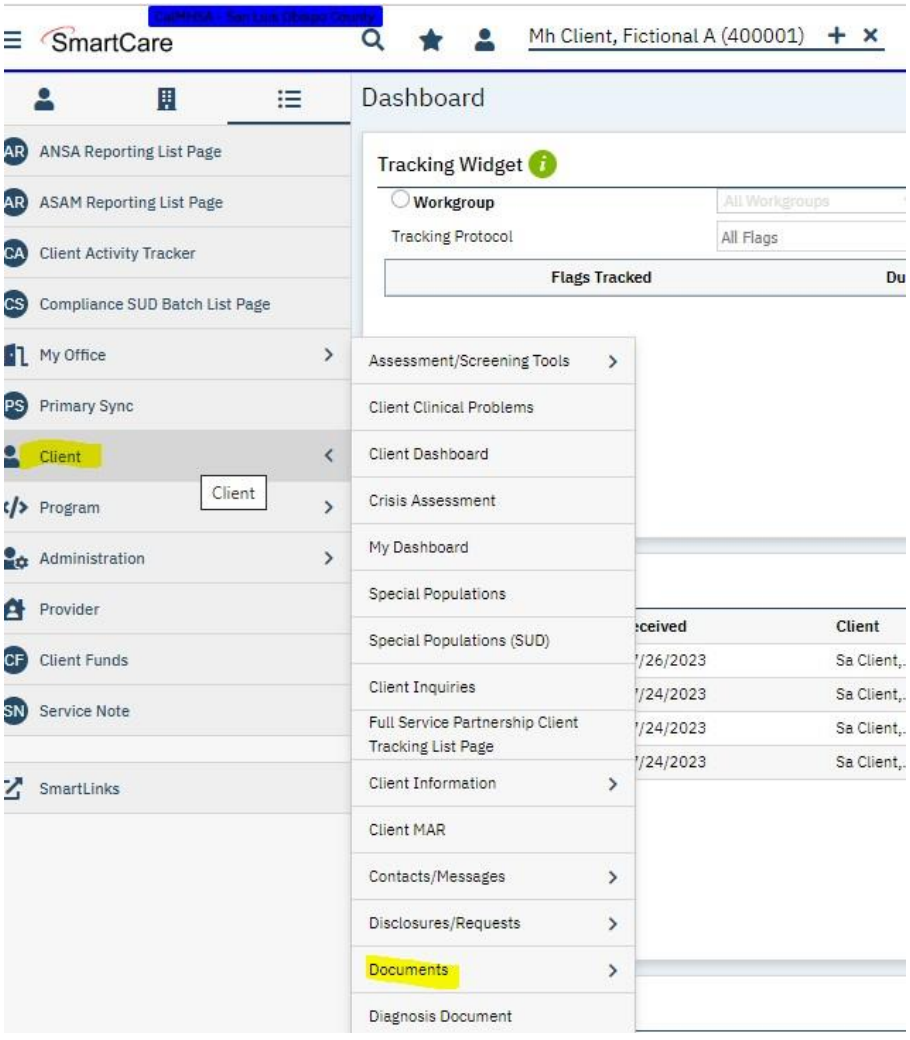
Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Martinez, Jennifer Ramirez		NCA MHSA Case Mgr Youth (2089)	jmartinezramirez@co.slo.ca.us	

Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Kindem, Anneliese Lorraine D		SLO Clinic Intake Youth (1601)	akindem@co.slo.ca.us	

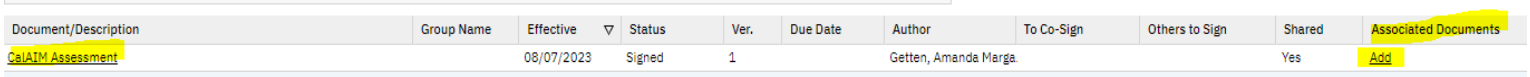
Appendix M – How to Associate a Progress Note with a Document

After the Program Supervisor, or designee, has reviewed a document or progress note in SmartCare, the Program Supervisor will complete a nonbillable service must document progress note to document the site authorization team determination. The Program Supervisor, or designee, will attach this Progress Note to the completed document or progress note by:

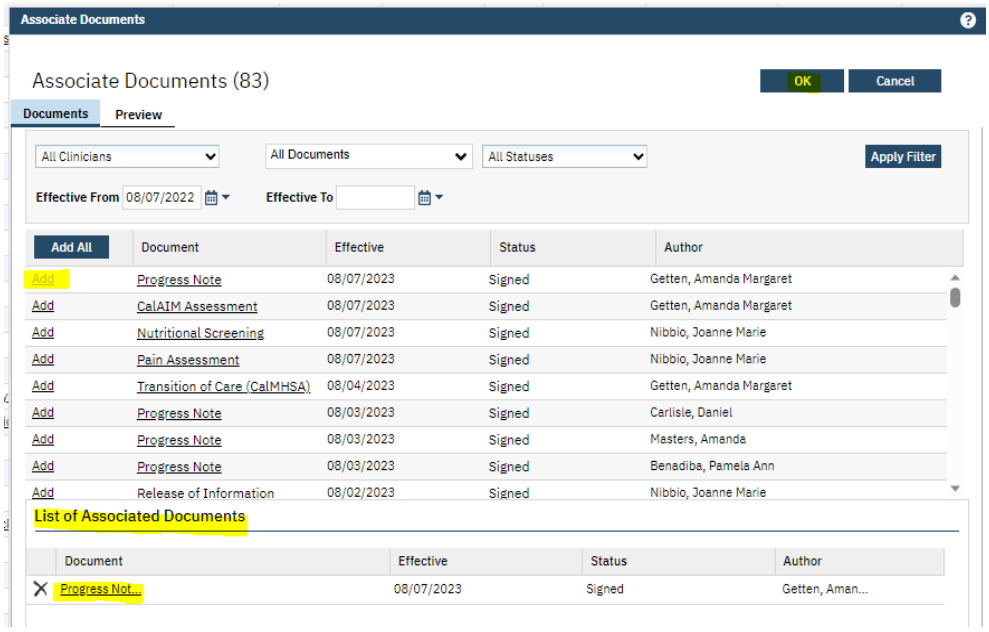
1. Open Documents List page



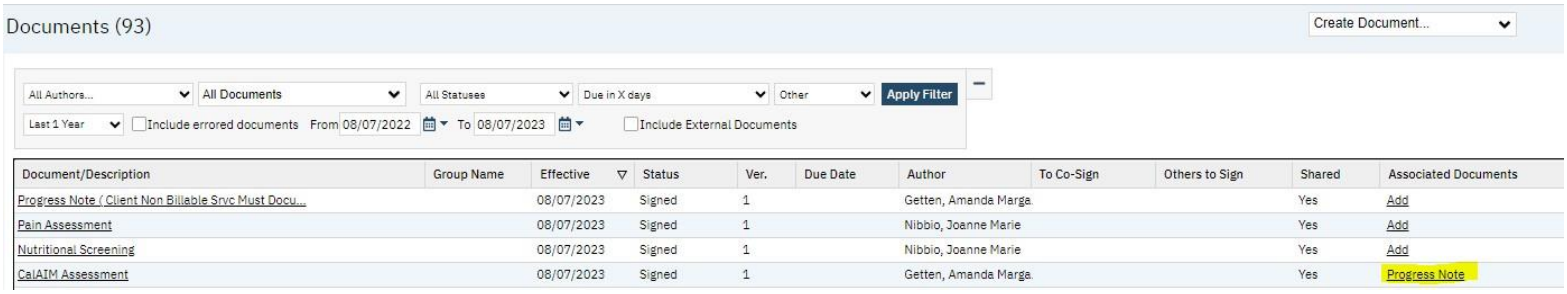
2. Find the document/progress note on the document list page and click **Add** under Associated Documents



3. Click **Add** next to the non-billable service must document progress note you would like to associate with the CalAIM Assessment, verify the progress note is listed below on the List of Associated Documents, and click **OK**



Now, you will see this Progress Note and be able to click on the hyperlink to the Progress Note from the Documents List Page:



Appendix N – Post PHF, Post CSU, Post Jail, Post MHET Appointment Workflow & Progress Note Examples

Post Appointments Open Clients Workflow

Make Sure They Are Safe	•Use "saftey plan client" questions in SmartCare •Short substance abuse screen: "do you use substances?" "Do you need/want help with your substance use?" •Assess current saftey- ask direct questions about current suicidal tendencies and ideations
Make Sure They Have Meds	•Are there any side efffects to the meds they're on? •Are there barriers currently to getting meds? •Did they receive meds on inpatient unit?
Make Sure There Are Plans for Future Services	•Follow up with PCP •Do they have future appointments set up with the county? •Assist client in putting hotline number in phone for easy access
Discuss What Led To The Event	•Go over safety plan and coping skills •"In your own words what happened?" •"What lead up to this event?" •"Could anything have prevented this event?"
Discuss Resources Avalible	•What additional support do they need? •Should they be connected with a case manager or community parnter? •Give them clinic 24 hour line (800-783-0607) and other crisis resouces
Discuss Next Steps	•How can this be prevented in the future •Get release of information (their current phone number, suport persons phone number, ect) •Discuss where the client will store their safety plan

Post Appointments for Clients Not Currently Open to Services Workflow

Make Sure They Are Safe	• Use "saftey plan" questions in SmartCare • Short substance abuse screen: "do you use substances?" "Do you need/want help with your substance use?" • Assess current saftey- ask direct questions about current suicidal tendencies and ideations
Make Sure They Have Meds	• Are there any side efffects to the meds they're on? • Are there barriers currently to getting meds? • Did they receive meds on inpatient unit?
Discussion of What Led Up To The Event	• Go over safety plan and coping skills • "In your own words what happened?" • "What lead up to this event?" • "Could anything have prevented this event?"
Discuss County Services and How We Could Help	• Explain the county services (Therapy, meds, etc.) • Talk about the treatment team and what they do (perscriber, case manager, etc) • When services are avalible and how (Medi-cal, etc.)
If They Do Want Services	• Set Up their next appointment • Explain to them the process, what to expect, the wait for a therapist if they want one, etc
If They Don't Want Services	• Should they be connected with a case manager or a community parnter? • What resources in the community might be the most helpful?

Discuss Other Resources	• What additional support do they need? • Give them clinic 24 hour line (800-783-0607) and other crisis resouces • Discuss where the client will store their safety plan
Make Sure There Are Plans for Future Services	• What is their next step with or without county resources? • Have a follow up with PCP • Assist client in putting hotline number in phone for easy access
Discuss Next Steps	• How can this be prevented in the future • Get release of information (their current phone number, suport persons phone number, etc) • Discuss where the client will store their safety plan

Post-PHF/CSU/Jail/MHET Progress Note Example (Specialist/Clinician)

Information/Interventions:

- Acknowledged the client's efforts to take care of their mental health by attending this Post-PHF/CSU/Jail appointment to encourage their continued efforts to attend services and to build rapport.
- Assessed for current safety by asking direct questions about current suicidal ideation, planning, attempt, or self-harm behaviors since the client's release from the PHF/CSU on xx/xx/xxxx. Client reported that he/she/they have not experienced suicidal ideation, planning, attempt, or self-harm behaviors since they were discharged from the PHF.
- Completed a brief screening of substance use by asking the client about current use and if they wanted/need help with substance use.
- Helped client identify what lead up to their PHF/CSU intervention and if anything could have prevented their crisis.
- Engaged the client in a review of their safety plan to monitor that it was up to date. Part of the safety plan review included a discussion about how coping skills, social supports, and community resources may help prevent a crisis in the future.

- Engaged the client in a review of their safety plan and completed a safety plan update to add one additional emergency contact number and one additional social support phone number.
- Discussed with the client where they will store their safety plan so that they know where to access it during a crisis.
- Assisted the client with programming the Hotline phone number into their phone to promote ease of use of this resource should there be a crisis.
- Inquired with the client about additional support and resources that they need and supplied the following: DSS for food/cash aid, Veterans services.
- Obtained Releases of Information in order contact the client's other support persons in the event of a crisis.
- Reviewed the client's plans for ongoing County Mental Health services (assessment, medication evaluation, case management, and options for therapy services).
- Reviewed the client's plans for ongoing Mental Health services through their current providers (community therapist, community psychiatrist/PCP).
- Obtained a Release of Information for this Specialist/Clinician to make contact with community therapist/community psychiatrist to discuss the client's recent crisis and recommendation for continued services.

Care Plan:
Client has a MH Assessment appointment scheduled for xx/xx/xxxx. Client has a medication evaluation appointment scheduled for xx/xx/xxxx. Client was made aware that he/she/they can contact the clinic if they need to be connected to a case manager prior to these scheduled appointments. Client said that he/she/they would use the Hotline should they need to.
Client plans to continue Mental Health services through with the therapist that she/he/they already see in the community. Client made a follow-up appointment with their psychiatrist for xx/xx/xxxx during this service. Client said that he/she/they would use the Hotline should they need to.

Post-PHF/CSU/Jail/MHET Progress Note Example (LPT/RN)

Information/Interventions:
- Acknowledged the client's efforts to take care of their mental health by attending this Post-PHF/CSU/Jail appointment to encourage their continued efforts to attend services and to build rapport.
- Assessed for current safety by asking direct questions about current suicidal ideation, planning, attempt or self-harm behaviors since the client's release from the PHF/CSU on xx/xx/xxxx. Client reported that he/she/they have not experienced suicidal ideation, planning, attempt or self-harm behaviors since they were discharged from the PHF.
- Asked client if they received medication while at the PHF/CSU/Jail. Client reported that she/he/they started Prozac.

- Inquired with client if they are experiencing any barriers to getting their medications and client reported she/he/they are not.
- Asked client if they are experiencing any side effects from their medications and she/he/they reported that they are not.
- Completed a brief screening of substance use by asking the client about current use and if they wanted/need help with substance use.
- Helped client identify what lead up to their PHF/CSU intervention and if anything could have prevented their crisis.
- Engaged the client in a review of their safety plan to monitor that it was up to date. Part of the safety plan review included a discussion about how coping skills, social supports, and community resources may help prevent a crisis in the future.
- Engaged the client in a review of their safety plan and completed a safety plan update to add one additional emergency contact number and one additional social support phone number.
- Discussed with the client where they will store their safety plan so that they know where to access it during a crisis.
- Assisted the client with programming the Hotline phone number into their phone to promote ease of use of this resource should there be a crisis.
- Inquired with the client about additional support and resources that they need and supplied the following: DSS for food/cash aid, Veterans services.
- Obtained Releases of Information in order contact the client's other support persons in the event of a crisis.
- Reviewed the client's plans for ongoing Mental Health services (assessment, medication evaluation, case management, and options for therapy services).
- Reviewed the client's plans for ongoing Mental Health services through their current providers (community therapist, community psychiatrist/PCP).
- Obtained a Release of Information for this Specialist/Clinician to make contact with community therapist/community psychiatrist to discuss the client's recent crisis and recommendation for continued services.

Care Plan:

Client has a MH Assessment appointment scheduled for xx/xx/xxxx. Client has a medication evaluation appointment scheduled for xx/xx/xxxx. Client was made aware that he/she/they can contact the clinic if they need to be connected to a case manager prior to these scheduled appointments. Client said that he/she/they would use the Hotline should they need to.
Client plans to continue Mental Health services through with the therapist that she/he/they already see in the community. Client made a follow-up appointment with their psychiatrist for xx/xx/xxxx during this service. Client said that he/she/they would use the Hotline should they need to.