County of San Luis Obispo
Mental Health Services
Treatment Plans and
Documentation Guidelines

To report suspected inappropriate or questionable documentation, coding, billing or clinical practices:

Confidential Compliance Hotline
855-326-9623
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 SLO County 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.

GOLDEN THREAD
A client’s record should depict an integrated record of treatment and have a “flow”, sometimes referred to as “The Golden Thread”. The graphic below represents the way different parts fit together.

An initial comprehensive Assessment or Annual Treatment Summary, along with a Diagnostic Review, document a client’s strengths, symptoms, functional impairments, risks, diagnosis, and important history. These documents are crucial for establishing the initial pieces of medical necessity and framing what treatment will accomplish. A Treatment Plan (TP) identifies specific, quantifiable goals to address issues found in the assessment. A TP is a collaborative effort that contains proposed interventions by staff and action steps the client will take to achieve the goals they identify together. Progress Notes document the actual interventions used by staff and memorialize the client’s action steps in achieving the objectives laid out in the TP. The Documentation Guidelines address these individual elements in the Golden Thread as well as ways staff will bring the pieces together into a complete record.
Definition of Key Terms

Adult Needs and Strengths Assessment (ANSA)/Child and Adolescent Needs and Strengths (CANS): We use the ANSA and 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 PHF is a Mental Health client, whether or not the admission is voluntary. We assign a medical record number to a client in the electronic health record.

Medical Administrative Activities (MAA) are not Specialty Mental Health Services and are not provided to open clients (except Medi-Cal Eligibility Intake (415)). If not already registered in Anasazi, persons who receive MAA are entered in Anasazi by name, but are not assigned a medical record number. MAA activities are documented in Anasazi in the individual’s record whenever the client’s name is known. See Appendix for more detail regarding MAA.

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 BH 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. Services provided after we obtain informed consent for treatment can be billed to an appropriate treatment plan. For more information about Minor Consent Services and signature requirements for minors, please refer to Appendix.

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

“Planned” and “Unplanned” Services: In Anasazi, “planned” means an intervention that is included on a Treatment Plan. Crisis Intervention is an “unplanned” service; Assessment may be planned or unplanned, but it is clearer if it is planned (on the TP), too. All other services must be on a Treatment Plan.
Face to Face contact – Includes services provided both in-person and via a two-way, real time, interactive audio and video communication.

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). This definition essentially replaces Licensed Practitioner of the Healing Arts (LPHA).

    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.

  - **“Approved Category of Staff”**: Approved category of staff are those who can approve Treatment Plans. This group includes any: Physician, licensed/waivered Psychologist, LMFT/LCSW/LPCC, Registered Associate MFT, Registered Associate Clinical Social Worker (ASW), Registered Associate PCC, or RN. “Registered” means enrolled with the appropriate California licensing board and assigned (not awaiting) a registration number. “Waivered” refers to a DHCS-issued Professional License Waiver and only applies to psychologist candidates and LMFT, LCSW, and LPCC staff recruited from out-of-state who are awaiting licensing examination in California. SLOBHD has a procedure for waiving the requirement that Clinical Supervisor must sign the documentation created by a Registered Associate. See current policy for more detail.

  - **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,
Medical Necessity for Outpatient Specialty Mental Health Services (SMHS)

Diagnosis Criteria + Impairment Criteria + Intervention Criteria = Medical Necessity

**Diagnosis Criteria**
Must have an included mental health diagnosis (CCR Title 9 §1830.205 (b)(1))

*Anasazi Evidence:*
Diagnosis Review
✓ Must contain an included diagnosis

Assessment or Annual Treatment Summary:
✓ Medical Necessity radio button question # 1: “Client has an included diagnosis” must be marked “Yes”

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

**Impairment Criteria**
Must have A, B, or C as a result of the included diagnosis (CCR Title 9 §1830.205 (b)(2)(A-C))

A. A significant impairment in an important area of life functioning

*Anasazi Evidence:*
Assessment or Treatment Summary:
✓ One or more “Severe” ratings due to mental illness on CANS/ANSA Functional Impairment rating scales and drop down list

✓ Briefly describe severe impairments in ‘Functional Impairment Comments’ test box. Sample phrases:
  - ...can only be treated with specialty mental health services (SMHS)
  - ...likely to decompensate and require a higher level of care without SMHS
  - ...required LPS conservatorship to ensure access to treatment. SMHS are required to prevent marked deterioration
**Medical Necessity radio button question # 2: “Client has a significant impairment....” must be marked “Yes”**

**B. A probability of significant deterioration in an important area of life functioning**

*Ariasazi Evidence:*
Assessment or Treatment Summary:
- One or more “Moderate” ratings due to mental illness on CANS/ANSA Impairment rating scales and drop down list

- Briefly describe risk of deterioration in ‘Functional Impairment Comments’ test box.
  Sample phrases:
  - ...requires SMHS to maintain current gains
  - ...requires SMHS to prevent decompensation
  - ...requires SMHS to prevent need for higher level of care
  - ...requires injectable medication (or an EPSDT service like ICC, IHBS, or TBS) that is only reasonably available as a SMHS....

**Medical Necessity radio button question # 2: “Client has a significant impairment....” must be marked “Yes”**

**C. A reasonable probability that a child (under 21) will not progress developmentally as individually appropriate**

*Ariasazi Evidence:*
Assessment or Treatment Summary:
- One or more “Moderate” ratings due to mental illness on CANS/ANSA Impairment rating scales and drop down list

- Briefly describe how development will be impaired without SMHS in ‘Functional Impairment Comments’ test box:
  - ...without SMHS, current gap in social functioning is likely to widen...
  - ...without SMHS, client is likely to fall further behind peers in...

**Medical Necessity radio button question # 2: “Client has a significant impairment....” must be marked “Yes”**

**Intervention Criteria**
A, B and C must be true (CCR Title 9 §1830.205 (b)(3)(A-C))

A. The focus of the intervention is to address the included diagnosis or impairments
Anasazi Evidence:
Treatment Plan:
✓ The interventions listed in the Treatment Plan must logically link to the impairments that result from the included diagnosis

Assessment or Treatment Summary:
✓ Medical Necessity radio button question # 3: “Specialty MH services are likely to help....” must be marked “Yes”

Progress Notes:
✓ Planned Progress Notes link the Intervention to the Objective in the Clinical tab

B. The intervention will – at least one must be reasonably expected true:

• Significantly diminish the impairment
• Prevent significant deterioration in functioning
• Allow the child to progress developmentally as appropriate

Anasazi Evidence:
Assessment or Treatment Summary:
✓ Medical Necessity radio button question # 3: “Specialty MH services are likely to help....” must be marked “Yes”

✓ The specific reasons for a “No” (“not likely to benefit”) conclusion must be clearly documented and must be based on recent treatment (within the last 90 days) and a current assessment of the beneficiary’s motivation/readiness for change.

Progress Notes:
✓ The Progress Note must show how the service is intended to help the client and must describe the actual Intervention

C. The condition would not be responsive to physical healthcare-based treatment
(Includes medication and other services provided by a Primary Care Physician, non-specialty mental health services provided by the Community Health Centers, Community Counseling Center, or the Holman Group)

Anasazi Evidence:
Assessment or Treatment Summary:
✓ Medical Necessity radio button question # 4: “Specialty MH services are required” must be marked “Yes”
Document the specific reasons for the yes or no answer based on recent treatment (within the last 90 days) and a current assessment of the beneficiary’s motivation or readiness for change.

**Early Periodic Screening Diagnosis and Treatment (EPSDT) Medical Necessity**

Full Scope Medi-Cal beneficiaries under age 21 only

**Diagnosis:** (same as above – client must have an included diagnosis)

**Impairment:** Severe or Moderate Functional Impairments are **not** required for EPSDT services if the client meets Diagnosis and Intervention Criteria

**Anasazi Evidence:**

**Assessment or Annual Treatment Summary:**

- Medical Necessity radio button question # 2: “Client has a significant impairment....” may be marked “No”

- If the CANS Functional Impairment rating scales are rated mild or none, document the parental and environmental factors that are likely limit access to care without SMHS

**Example:**

- ...*SMHS are needed to reduce his symptoms because (describe the parent or other environmental risk factors which would limit access without SMHS)*

**EPSDT Intervention Criteria** A and B must be true (CCR Title 9 §1830.210(a); CCR Title 22 §51340(e)(3)(A) and §51340(f))

**A. EPSDT services are necessary to correct or ameliorate the mental illness...**

**Anasazi Evidence:**

**Assessment or Treatment Summary:**

- Medical Necessity radio button question # 3: “Specialty MH services are likely to help....” must be marked “Yes”

**Progress Notes:**

- The Progress Note must show how the service is intended to help the client and must describe the actual Intervention

**B. The condition would not be responsive to physical healthcare-based treatment**
(Includes medication and other services provided by a Primary Care Physician, non-specialty mental health services provided by the Community Health Centers, Community Counseling Center, or the Holman Group)

Anasazi Evidence:
Assessment or Treatment Summary:
✓ Medical Necessity radio button question # 4: “Specialty MH services are required” must be marked “Yes”
✓ Document the specific reasons that EPSDT services (like TBS, ICC, or IHBS) are required and why brief therapy by a Holman Provider is not sufficient

Factors to consider and document include:
• Complex or multiple medical or mental health conditions or high use of services
• Presence of environmental risk factors (parent or other factors which would limit access without SMHS)

Note:
We often say that a client “meets medical necessity” when all three criteria discussed above are true. You may also hear that services are “medically necessary” when the services are of a type and are in an amount that are reasonable and likely to produce the desired outcome for the client. Our goal is to provide the right services in the right amount to the right clients in order to meet their needs.

Refer to policy 3.20 Authorization of Services and Medical Necessity for a more information.

Click here to see a list of Sample Medical Necessity comments


| Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders | F20.0-F29 |
| Mood [affective] disorders | F30.10-F39 |
| Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders | F40.00-F48.8 |
| Behavioral syndromes associated with physiological disturbances and physical factors | F50.00-F50.9, F53-F53.1 |
| Disorders of adult personality and behavior | F60.0-F60.1, F60.3-F60.9, F63.0-F65.9 |
Pervasive developmental disorders, including Autism Spectrum Disorder  F68.10-F69
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence  F84.0–F84.9
Extrapyramidal and movement disorders*  G21.0-G21.19
* Included only when the Medication Induced Movement Disorder is related to an included diagnosis that is also coded on the Diagnostic Review

Excluded ICD 10 Diagnoses:
Mental disorders due to known physiological conditions  F01-F09
Mental and behavioral disorders due to psychoactive substance use  F10-F19
Behavioral syndromes associated with physiological disturbances and physical factors  F51-F52
Disorders of adult personality and behavior  F60.2
Antisocial Personality Disorder  F66
Other Sexual Disorders
Intellectual disabilities  F70-F79
Pervasive and specific developmental disorders  F80
Specific developmental disorders of speech and language  F81
Specific developmental disorders of scholastic skills  F82
Specific developmental disorder of motor function  F88
Other disorders of psychological development  F89
Unspecified disorder of psychological development  F99
Unspecified mental disorder  F99

Progress Notes

GENERAL CONSIDERATIONS
Progress 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.

Progress Notes must document relevant aspects of client care, including clinical decisions made, interventions used, and referrals given to the client. Extraneous information, especially negative comments about other staff members or other clinical disagreements, do not belong in the record! SLOBHD Progress Notes are not process or “psychotherapy notes” defined in HIPAA (CFR 45 §164.501).
Progress Notes must describe how the intervention reduced a client's impairment, restored functioning, or prevented significant deterioration in an important area of life functioning described in the Treatment Plan. **In other words, a Progress Note explains what was medically necessary about the service.**

Merely transporting a client or performing clerical tasks are **not** billable services, because no intervention occurred that would benefit the client.

Progress Notes document the link between the client's diagnoses/impairments (from an Assessment or Focus of Treatment on the TP), Objectives (from the TP), and the Interventions provided during the service. However, it is not necessary to restate the client's diagnosis or impairment in each Progress Note – document those aspects of medical necessity in the Assessment and Treatment Plan.

**Progress Notes document how the intervention provided will help reduce impairment, prevent deterioration, or restore functioning (See pages 4-8 for a detailed description of the Intervention Criteria).**

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**Frequency**
Document every outpatient service contact in a Progress Note. Day Treatment Intensive and Adult Residential have separate frequency requirements.

**Timeliness***
- **Outstanding:** On the date of service
- **Above Satisfactory:** Within 2 calendar days of the date of service
- **Satisfactory:** Within 4 calendar days of the date of service
**Improvement needed/billable:** 5-14 calendar days of the date of service. Any Progress note written more than 5 calendar days after the service must begin with the phrase “Late Entry” in the top line of the note. While notes written 5-14 days are billable, our goal is more timely documentation to ensure a high level of service to our clients.

**Unsatisfactory/unbillable:** More than 14 calendar days after the service. Progress Notes written more than 14 calendar days after the date of service should still be entered for the sake of continuity of care; record the duration of service, but select “Late Entry” for Billing Type on the Billing Ribbon and write “Late Entry” at the top of the note. The service will not bill. If late documentation occurs regularly, talk with your Program Supervisor about strategies to you can use to get notes completed in a timely manner.

**Sample timeline for a service provided on 5/1/2017:**
- Outstanding: Note completed on 5/1/2017
- Above Satisfactory: Note completed on 5/2/2017 or 5/3/2017
- Satisfactory: Note completed on 5/4/2017 or 5/5/2017
- Improvement Needed: Note completed between 5/6/2017 and 5/14/2017
- Unsatisfactory/Unbillable: Note completed on 5/15/2017 or later

*SLOBHD allows a few exceptions in extenuating circumstances; must be approved by Medical Director and QST Division Manager on a case-by-case basis

**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. Most 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**
Remember that the law allows clients, representatives, and others broad access to their record. It is safest to assume that others will read what you write.

- **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 A 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.
**Case Consultation/Case Conference:**
Adoption of the Core Practice Model (CPM) for the treatment of youth involved in multiple agencies continued a trend toward coordinated care. DHCS now allows staff to document and claim time spent in care coordination for clients of all ages. Generally, 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.

Staff must describe their role, the role of others in attendance, and the purpose of the case conference in the Focus of Session section of the note. Document decisions or other information discussed during the conference in the Clinical Decisions and Interventions section of the note. Clearly state how the information will affect client care. Each staff member who claims for the Case Conference must write a separate Progress Note.

**Service Codes:**
- Plan Development: Use if the case conference results in a new TP or a Review of a TP
- Assessment: Use if the information will be used in the Assessment or annual re-assessment of the client
- Case Management: Use if the focus is coordination of services, monitoring progress, providing linkage or referrals, etc.
- Intensive Care Coordination: Use ICC to document all Child Family Team meetings and all other Case Management-like services for youth under 21 who are being served in a CPM/CFT.

**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. Add a statement to the intervention section of the note that reflects what you did. For example, “Reviewed record to gather treatment history for assessment...” Record review may apply to services claimed by the minute, such as:

- Assessment, Plan Development, Collateral, Rehabilitation, and Therapy
- Targeted Case Management
- Medication Support Services
• Crisis Intervention

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

**INDIVIDUAL PROGRESS NOTES**

**Behavioral Health Progress Note Template**

This is the standard template used for most billable outpatient service contacts.

**Focus of Session:** The purpose of this section is to explain why the service occurred, how it will help the client, and to document any significant symptoms, behaviors or mental status elements noted during the service. Here you are answering the question, **“Was the service medically necessary?”** not **“Does the client meet medical necessity?”**

When staff write a Progress Note for a client with a Treatment Plan (TP), selecting an Intervention and an Objective electronically link the Progress Note to the Impairment and Focus of Treatment on the TP. Therefore, the Focus of Session section in the Progress Note can be brief. 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 Progress Note.

**Interventions:** Interventions 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 and are the most important part of the note. 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...

**Client’s Response:** Most interventions are directed toward the client, but sometimes directed toward someone other than the client (e.g. family). The Response section is where you write about how recipient(s) of the service react or respond to your Interventions.

**Plan:** 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.

**Signatures:**
- Electronically sign the Progress Note as soon as possible after the content is complete to create a date and time stamp that verifies when you wrote the note. It is unethical (and perhaps fraudulent billing) to launch and sign a Progress Note and then return to write the content at a later date if the intent is to create a false impression about when the note was written. All activity in the record includes a date/time stamp. Dictation creates an exception to this rule: if a note is dictated, it is acceptable to launch and sign the note at the time the note is dictated, then paste the transcribed content in later.
- Obtain all required signatures and Final Approve as soon as possible. Final Approval limits the ability to change content, which is important for maintaining the integrity of the client’s treatment record. An Addendum may be added to the Progress Note later if needed.

**Encounter Data/Service Indicators:** The “Billing Ribbon” contains important billing and Client & Service Information (CSI) reporting data. Appendix B lists and defines all the Service Indicators, but here are a few key values:

- **Person Contacted:** Usually Person Contacted is who is present or who the service is provided to. We track our participation in Child/Family Team (CFT) meetings using a special value “Child and Family Team (Enter “T” as a shortcut). Use this value for all CFT meetings.

- **Service Intensity:** We track timeliness from request to service for crisis and urgent services. Recently, we made a change to comply with the Federal Managed Care Rule and to align with the Knox-Keene standards that apply to other medical services. Select from the following Service Intensity types (for the complete list, see Appendix B):

<table>
<thead>
<tr>
<th>Service Intensity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C Crisis: Within 1 hour</td>
<td>Use only with Crisis Intervention or MAA Crisis service codes. Response time is within 1 hr. of the client's call in or walk in request for services.</td>
</tr>
<tr>
<td>D Crisis/Urgent: Within 48 hours</td>
<td>Use only with Crisis Intervention or MAA Crisis service codes, because crisis services do not require preauthorization.</td>
</tr>
<tr>
<td>U Urgent: Within 4 Days (96 hours)</td>
<td>Use with any service other than Crisis Intervention or MAA Crisis. Other services require preauthorization. Days are calendar days.</td>
</tr>
<tr>
<td>R Routine</td>
<td>To providers other than MD or NP = within 10 business days of request To an MD or NP = within 15 business days of request</td>
</tr>
</tbody>
</table>

- **Travel Time:**
  - Travel to or from a field-based service is billable only if a service occurred

Click here to jump to Appendix D for information about travel billing
Click here to jump to Appendix J for information about travel versus transportation

- **Cancellation and FTS:**
  - Edit the Billing Ribbon to change the **Duration** to 0:00*
  - Edit **Appointment Type** to “No Show” or “Canceled By …” as appropriate

Use the Non-Intervention Progress Note template to document the reason for the note (e.g., “Client FTS”) and any follow up action you took (e.g., “Attempted to call client – no answer.”).

*If you prepared for an Assessment or Plan Development service by reviewing the record, you can claim reasonable record review time as Service Time, even if the client FTS. In this instance, enter the time and document your intervention.

**GROUP PROGRESS NOTES**
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 “Overview Progress Note” section. 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 interventions and are not included in the Progress Note.

“Overview Progress Note” section:
1. Do not use BH Progress Note template in this section
2. Name of Group or Topic of Group:
   - Examples: “Hope House Workshop: Overcoming Barriers to Achieve Goals”
   - “Managing Money Wisely”
   - “Solving Conflicts Peacefully”
3. Write the purpose of the group here
   - Examples: “Goal of group is to develop conflict resolution skills to help clients improve social relationships.”
   - “Workshop provides participants with the opportunity to learn budgeting skills to help them maintain housing.”
4. Group Interventions:
   Write your specific skill building interventions for the entire group here
   - Examples:
     - Taught the group to develop a budget by listing expenses…”
     - Modeled effective communication
     - Rehearsed ...
     - Role played ...
     - Practiced ...


“Client Progress Note” section:
1. Insert the Behavioral Health Progress Note Template here – see above for details.
2. Individualize the note by listing any interventions or decisions for each group member.
3. Each client has unique interactions with other group members and reaction to the topic; document the individual responses clearly in the Client’s Response section.

When two staff provide a group service, each staff must write a Progress Note for the service. Each Progress Note must clearly indicated the reasons both staff are necessary to run the group and what each staff contributed to the service. The service must be within the scope of practice of both staff.

INFORMATIONAL NOTES
Create an Informational Note when documenting an unscheduled activity that is not a service.
- 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.

**Example:** “Met with client and discussed housing options. Fax ed form to TMHA (not billed)”.

◊ **Specialty Mental Health Services◊**

**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, a medical necessity 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 code in the EHR. And, of course, assessment in our EHR is another word for form. Because we often use the word to mean different things, key FAQs are detailed below.
Assessment FAQs

- Some assessment processes must be conducted face-to-face with the client. A Mental Status Examination (MSE) and behavioral observation to formulate initial diagnostic impressions are examples.

- Other assessment activities may be performed either face-to-face 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 the purpose of the contact is to gather information for an intake assessment, code it as “MH Assessment” (Service Code 100).

**Note:** The assessment process must include a face-to-face meeting with the client to be complete, because an MSE is an important component of an assessment. If an assessment form is started but is not completed because the client terminates the contact or does not keep a follow up appointment, complete the form to the degree possible and document the reason the process is incomplete in the Recommendations/Plan of Action section and on a Progress Note. Use the MH Assessment Service Code to account for the time spent on the assessment. Add a Staff signature line with the heading “Incomplete Record Confirmation” to the assessment to affirm that the assessment is not complete. Close the case. 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 BH Consent for Treatment to document their understanding and agreement to participate in treatment.

- MD/DO/NP signature on the intake assessment is only required for clients with Medicare coverage. Otherwise, do not route the initial assessment to an MD for signature.

Assessment Progress Note FAQs:

- Clinicians must give and review informational material with every client, in a language understood by the client, at the intake appointment. The Assessment Progress Note template lists the requirements – just place an X next to the items discussed/given.

- It is best practice to include Assessment as an intervention on the Treatment Plan (TP), but Assessment Progress Notes may be “Unplanned” in Anasazi. The issue is that it can be difficult to write and unplanned note. Each long-term client will receive periodic assessment updates, so it makes sense to add the Intervention to the TP. All current Formatting Guides include Assessment to make things easier for staff.
• The total time for the assessment must be reasonable and supported by the documentation contained in the Progress Notes and in the intake assessment form. Most comprehensive assessments take about 4 - 6 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.

• If more than one assessment service is provided, the template is only required once (Usually for the session when informational materials were given). It is best practice to write a separate Progress Note for each assessment service if they occur on different days. For example, if staff meet with a parent on Monday and with a youth on Thursday, each service would be documented on a separate Progress Note.

• Billing Ribbon/Encounter Data: Bundle interview(s), record review, and write up of the Diagnostic Review and Assessment in Anasazi as “Service” on the Billing Ribbon (best practice).

• Refer to the Assessment or Treatment Summary in your note to link the document to the service you provided. When you reference an Assessment or Treatment Summary in your note, you may include less detail for Focus of Session and Interventions because the reader will go to the larger document for clinical detail.

Example:
Focus of Session:
“I met with client to review progress over the past year and to evaluate current functioning prior to updating TP”

Clinical Decisions and Interventions:
“I met with client and completed Annual Treatment Summary. Client continues to meet medical necessity criteria for services. See Annual Treatment Summary for detail.”

Click here to view an example of an Assessment Progress Note

Annual Treatment Summary/Assessment Updates

Question: What is the difference between an Assessment and an Assessment Update/Treatment Summary)?
Answers:
An initial Assessment is a comprehensive review of history, symptoms, impairments, mental status, etc. – all the elements in the Title 9 definition of assessment plus all the required elements listed in Policy 5.00, Outpatient Mental Health Assessment and SLOBHD’s contract with DHCS. Each client record must include one comprehensive assessment, usually completed at the time the client begins services. Staff may complete an additional comprehensive assessment whenever clinically indicated. Alternatively, staff may use an Annual Treatment Summary/Assessment Update to add new assessment information to the client record when a comprehensive assessment is in the electronic record. An Annual Treatment Summary/Assessment Update contains many, but not all, of the elements in a comprehensive assessment. Staff do not need to repeat static elements like family or developmental history if those elements are in the comprehensive assessment in Anasazi. Staff use the update to document changes since the last assessment or update for other elements, such as treatment history, progress, etc. Staff document the current functional impairment, risk, and need for services with each update.

Question: When (how often) do I use the Treatment Summary?
Two part answer:
Annually (ideally right before you develop the next Treatment Plan)
• To update progress during the past year and to identify usable strengths for ongoing treatment
• To help identify reasons for continued treatment (medical necessity)
• To help match objectives for the next Treatment Plan (TP) with current needs and strengths
• To generate ongoing outcome measure data by completing the Adult Needs and Strengths Assessment (ANSA) and Children’s Assessment of Needs and Strengths (CANS) rating questions

Whenever an clinically indicated after a significant change for the client
• After a significant life event (i.e., D/C from a hospital, release from jail or after a trauma)
• When a client leaves treatment but returns and is reopened within 90 days of closing
• Whenever there is a significant change (positive or negative) in a client’s level of functioning
• Any other time an update will provide useful clinical information

Question: Who can complete the Treatment Summary?
Answer:
All clinical staff after CANS/ANSA training and certification
• Normally, the SAI completes the form, but when more than one staff member is involved in a client’s care, staff may collaborate to complete the form. Add staff signatures so that everyone who contributes can sign.

Question: How do I document when I complete a Treatment Summary?
Answers:
Time:
Bundle the time you spend completing the Treatment Summary, consulting with the treatment team, and the time you spend with the client as “Service” time in the Progress Note.

Service Code:
- Licensed therapists/registered interns/trainees: Use Assessment (100)
- PT/LVN/RN: Use Case Management (200) or ICC (221)
- All clinical staff: If you complete the Treatment Summary and Revise or Review the Treatment Plan in one session, bundle the time and write one Progress Note. Use Plan Development (210).

Tips: Coordinate the Annual Treatment Summary with the completion of other annual tasks (renewing Authorizations to Use/Disclose PHI, developing a new Treatment Plan, etc.) or to plan a transition to a lower level of care.

Case Management Services
Definitions
Targeted Case Management
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)

Case Management for Severely Emotionally Disturbed (SED) Youth
1. Coordinating an ecological assessment of the child's needs, which evaluates the child both individually, and in relation to his or her family, school, and community environments.
2. Developing, implementing, monitoring, and reviewing each individual Treatment Plan that addresses the identified needs.
3. Linking and arranging or providing for the needed services.
4. Monitoring the adequacy of the services provided.
5. Advocating for the minor. (WIC 5699.1 through 5699.5)

Choosing between Case Management and Plan Development
Case Management: Reading/discussing the Treatment Plan with the client or support person, monitoring progress without making changes to the Treatment Plan, or completing a transfer summary is Case Management for all clients.

Plan Development: Creating a new Treatment Plan or making any change (Revise or Review) to an existing Treatment Plan is Plan Development for all clients, including youth.

Examples of Case Management
- “I spoke with client to gather information about current functioning for diagnosis update,
which will be presented to MD.”

- “I referred client to Community Counseling Center.”
- “I attended a meeting with parent to advocate on behalf of client so her after-school program is not terminated.”
- “I attended an IEP for client to gather information about school behavior and advocate for modifications to classwork to ...”
- “I called Probation Officer (PO) and gave him an update on client's progress in the group. I explained ....”
- “I consulted with the treating Staff Psychiatrist to...”

**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 Case Management. 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

Here is an example of a Case Management Progress Note that follows these tips:

**Focus of Session:**
Mary arrived for her scheduled appointment and asked me to help link her to Housing Authority of San Luis Obispo. Mary reports that she is losing her housing in two months and she feels too overwhelmed to take any action. Her mood symptoms (inability to concentrate, hopelessness, and tendency to shut down when feeling overwhelmed) prevent her from completing the application or accessing community resources on her own. Without assistance, she is highly likely to deteriorate to the point that she needs a higher level of care to meet her mental health needs.

**Clinical Decisions/Interventions:**
• Helped Mary identify needed resources and supports
• Discussed the importance of action (versus passivity) to reduce her depression
• Reminded Mary of her treatment gains and successes
• Prompted her to use her coping skills to reduce level of distress in session
• Assisted her in formulating answers and completing application
• Helped Mary develop a plan for managing anxiety while waiting for response to her application
• Typed and electronically filed her application (15 minutes, not billed)

**Note:** Billable Case Management activities related to making a referral include discussing a resource with a client, contacting the resource, completing a written referral form (including the referrals within Anasazi), 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 Progress Note.

Click here to view an example of a **Case Management Progress Note**

**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)*

Note: Collateral can be an individual (a meeting with one client’s parents) or group service (parenting class for multiple sets of parents). Collateral is not limited to youth! Strongly encourage clients to include extended family and significant support persons in treatment. Routinely add Collateral to TPs whenever significant support persons are involved with a client.

**Choosing between Collateral and Case Management**

Collateral involves contact with a significant support person (usually a parent, guardian or family member) and the use of an intervention, consultation with, or training of the support person in a specific skill to help the client. Contacts with teachers, probation officers, and other agency personnel (usually a paid professional) do not meet the “significant support person” definition. Contacts with family members to monitor progress or link to resources do not meet the intervention requirement – Case Management fits better.

**Examples of Collateral Services**
- “I reviewed behavior management ideas (reward system, sticker chart, etc.) with a parent.”
- “I reviewed reflective listening techniques with Jennifer’s parents. Family rehearsed this twice in the session with my help and then successfully on their own.”
- “I met with family members to help them understand client's Bipolar Disorder and ways to respond when symptoms cycle…”
- “I met with family members to help them develop a safety plan and to identify signs that client requires additional support…”

**Attending Med Evaluations to Assist a Client’s Significant Support Person**

Staff frequently join a med evaluation to support a family member or to relay necessary information to the MD. However, billing for two separate services (Med Support and Collateral) for the same activity is double billing. Meet with the support person before and/or after the med evaluation to help the support person better help the client. Document the time spent as a Collateral Service. Limit the duration on the Collateral Progress Note to the time spent before and after the medication evaluation (not the time the spent in session with the doctor). See **Case Consultation/Case Conference** for additional guidance.

Click here to view an example of a **Collateral Progress Note**

**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 Intervention FAQs**

- Crisis Intervention does not need prior authorization and is not included on the TP (Crisis Intervention Progress Notes are “Unplanned” in Anasazi).
- Prompt documentation is an important part of quality care, especially for clients in crisis.
- Choose the Intensity Type that best matches how quickly you responded to the client’s
request for crisis intervention.

Risk Assessment and the BH Crisis Intervention Assessment
SLOBHD implemented the BH Crisis Intervention assessment, to guide 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. For more information see the current resources posted on MySLO: https://myslo/BH Documentation Resources.aspx

Additional documentation tips:

- Use client quotes, when appropriate, to illustrate. 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

- Document any consultation with others

- Clearly document the follow-up plan. Examples: “Client will call PCP (461-xxxx) this afternoon” or “Client was 5150’d to PHF for evaluation”.

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
✓ Alert everyone on the team to the crisis, including FSP staff
✓ Another team member is able to respond or follow up sooner than you are able to, which may improve the results for the client

3. Work with 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 NP – having additional input can be very helpful!

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.

Choosing Between MH Crisis Intervention and MAA Crisis Referral
MH Crisis Intervention is a Specialty Mental Health Service provided to a client who has consented for treatment (evidenced by signature) and has an expectation of privacy. MAA Crisis Referral is an activity provided to a person who is not yet a MH client and is provided with the goal of referring the individual to MH (e.g., helping the recipient become a MH client). If an individual walks into a clinic in crisis, but will not continue in treatment, choose MAA Crisis instead of MH Crisis Intervention.

- MAA recipients are logged into Anasazi by name (if available), but are not assigned a new Medical Record number. If the recipient’s name is already in Anasazi with a record number, do not create a new record or change the existing number – use the existing record.
- Assign MAA recipients a MAA subunit (2601) to allow the crisis worker to document

Whenever possible, explain the risks and benefits of treatment (including the risks of refusing treatment) and obtain written consent for treatment. Document and code your clinical interventions as MH Crisis Intervention.

<table>
<thead>
<tr>
<th>Non-open Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scenario:</strong> Walk-in Crisis</td>
</tr>
<tr>
<td>If not in AZ, add Core Client</td>
</tr>
</tbody>
</table>

**Best Walk-in Option!**
Information (Index Card) and give a client number
- Demographic (update if already in AZ)
- Set UMDAP/gather Financial info
- Obtain signature on BH Consent for Treatment and BH Acknowledgement of Receipt of Privacy Practices
- Health History form is not required for crisis services!
- Assign to Crisis Worker using a subunit for your clinic or site

LPT/LVN staff gather symptom data, but do not render diagnoses. If the client will not see an LMHP staff (i.e., closing after crisis), choose MAA Crisis (416) instead
- Interim Service Log
- Individual Progress Note
- Contact Managed Care to schedule intake assessment

## Alternative:
(Use if client is able to complete Demographic and Consent for Treatment)

If not in Anasazi, complete Core Client Information (Index Card) as fully as possible. (Use 1/1/1800 if client can't/won't give a DOB.)
- Do not assign Medical Record #.
- Assign to Crisis Worker, Subunit 2601

MH Crisis Intervention (203)

### Scenario: Crisis Call
#### Front Office Responsible for:
- Ask client name, DOB and phone number.
- If not in Anasazi, complete Core Client Information (Index Card) as fully as possible. (Use 1/1/1800 if client can't/won't give a DOB.)
- Do not assign Medical Record #.
- Assign to Crisis Worker, Subunit 2601

#### Clinician Responsible for:
- Interim Service Log
- Individual Progress Note

#### Intervention Code:
MH MAA Crisis Referral (416)

### Alternative:
(Use if recipient unable to complete Demographic and Consent for Treatment, but gives name or will not be seen by an LMHP)

MH MAA Crisis Referral (416)

### Open Cases
### Scenario:

<table>
<thead>
<tr>
<th>Crisis call or walk-in</th>
<th>Contact clinical staff (SAI or Crisis worker)</th>
<th>Unplanned Individual Progress Note</th>
<th>MH Crisis Intervention (203)</th>
</tr>
</thead>
</table>

### Notes:
- Document the MAA crisis activity as fully as possible so your interventions are available to the next provider.
- Document efforts to link the client to MH for ongoing services.
- All requests for services must be logged in Anasazi, but the assignment and Progress Note accomplish this. **A Service Request is not required for crisis contacts.**

Click here to view an example of a **Crisis Intervention Progress Note**

### Intensive Care Coordination (ICC)

Intensive Care Coordination is a targeted case management (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). Select ICC, not Case Management (CM), for youth whenever a CFT is involved, including when writing transfer summary notes.

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, his/her 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 his/her home community.

While the key service components of ICC are similar to CM, ICC is an integral part of the CFT process, and it typically requires more active participation by the ICC provider in order to ensure that the needs of youth are appropriately and effectively met.

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 Treatment Plans 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 his/her 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.

**ICC Documentation:**

- ICC must be included on an Anasazi Treatment Plan (TP). Complete a TP Review. Modify current Objectives or add ICC to an existing Objective.

- Each staff who attends a CFT meeting may write a separate progress note that includes the length of the CFT meeting plus documentation and travel time. Any participation time claimed, which may include active listening time, must be supported by documentation showing 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 Treatment Plan).

**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.

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.

**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 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 Anasazi.

Preapproving the prescription and routing it to the MD:

- Ensures that the medication information is in Anasazi 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 Authorization to Use/Disclose PHI 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 BH Record of Disclosure in Anasazi. See Appendix for detail.

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 Support Progress 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. A maximum of four hours of Medication Support services can be billed in a 24 hour period (CCR Title 9 § 1840.372); Anasazi is set up to limit claims for medication support to the maximum
amount.

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

See *Med Support Visits* policy for more information.

Click here to view examples of *Medication Support Progress Notes*

Click here to view the *Medication Refill Workflow diagram*

**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)

**Plan Development FAQs**

- Plan Development involves developing or making a change to a Treatment Plan, except when presenting a TP or assessment at SAT

- Actively involve your client and/or family member(s) in creating a TP that guides the client’s treatment and document the client’s participation and agreement with the TP on the TP.

- Bundle time spent developing/writing the TP in Anasazi with a face-to-face or telephone service with the client. TP development in Anasazi is billable if linked to a service, but it is not a stand-alone service.

- Offer the client a copy of the TP.

**Choosing between Plan Development and Case Management**

**Plan Development:** Creating a new Treatment Plan or making any change (Revise or Review) to an existing Treatment Plan is Plan Development for all clients, including youth. Presenting and approving Assessments and/or Treatment Plans in SAT are also Plan Development services. A designated staff member writes a Progress Note to document the SAT's activity.

**Case Management:** Reading/discussing the Treatment Plan with the client, monitoring progress without making changes to the Treatment Plan, or completing a transfer summary is Case Management for all clients.
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 Rehabilitation Interventions
Most interventions involve teaching and skill-building:
- 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 him to recall events that preceded his xxx.
- Discussed the red flags with her 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 his/her 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 or Collateral) 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
her 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. See Case Consultation/Case Conference for additional guidance.

Click here to view examples of Individual and Group Rehab Progress Notes
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 Progress Note. 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.

Click here to view examples of Individual and Group Therapy Progress Notes

<table>
<thead>
<tr>
<th>Scenario:</th>
<th>Explanation:</th>
<th>Instructions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient services for a client who is at PHF/other psychiatric hospital</td>
<td>When a client is incarcerated or at inpatient psychiatric hospital, outpatient MH services are locked out.*</td>
<td>Write a Progress Note using the appropriate service code for the intervention performed. Select the appropriate Place of Service (“C” correctional facility, or “D” inpatient psychiatric facility). Include the service, travel, and documentation time. The service will suspend.</td>
</tr>
<tr>
<td>Outpatient services for a client are billed when a client is</td>
<td>Outpatient SMHS are billed when a client is</td>
<td>Write a Progress Note using the appropriate service code for the intervention performed.</td>
</tr>
<tr>
<td>Client who is at medical hospital (includes ED)</td>
<td>seen at an inpatient medical hospital or Emergency Department</td>
<td>Select the Place of Service (&quot;G&quot; Health Care or &quot;B&quot; Field). Include the service, travel, and documentation time.</td>
</tr>
<tr>
<td>Client is at IMD or State Hospital</td>
<td>When a client is at an IMD or State Hospital, no services can be billed (outpatient services are “locked out”).*</td>
<td>Write a Progress Note using the appropriate service code for the intervention performed. Select the Place of Service as MH Adult Residential (&quot;V&quot;). Include the service time. Select Unit 4000 and the corresponding Subunit for the IMD or State Hospital. No bill will be generated.</td>
</tr>
</tbody>
</table>

*Write a Case Management progress note when arranging appropriate placement during the last 30 days of a stay

| Client is at JSC | The Place of Service for Juvenile Hall is Y. | For clients in JSC, the Unit is always 1600. SLO Youth Services staff will open the correct Subunit depending on the client’s adjudication status. Staff providing a service to a client at JSC must use 1600 and the appropriate Subunit regardless of where the staff are located. It is the client’s location that determines the Unit 1600. |
| Client is at an Out-of-County Hospital | Use when a client is admitted to an out-of-county hospital until discharged.* | Open Unit 4400 and Subunit 4401. Write a Progress Note using the appropriate service code for the intervention performed until client is discharged. Select the Place of Service as Inpatient Psychiatric Facility (“D”). Include the service time. |
| There is No valid Treatment Plan | All services except Crisis need a TP. No Valid TP is not a replacement for building a TP! | If there is no Treatment Plan, contact the client to start developing a plan! Crisis Intervention is an “Unplanned” service in Anasazi. Assessment is better added to a TP, but may be billed as “unplanned”. |
| Second Opinions | Second opinions always involve an assessment or a review of an assessment by LMHP | Write a Progress Note using the appropriate service code for the intervention performed. For Billing Type, select “Second Opinion”. No bill will be generated and the beneficiary is never charged for the service. |
| Spanish-language Interpretation | Translation is not a billable service. Staff who provide translation | If a bilingual staff member conducts a service in Spanish, use Contact Type P (Telephone Spanish) or S (Face-to-Face Spanish). |
Services

are not collateral servers. Select the appropriate time card code to account for time translating for other staff.

When a Spanish-speaking staff member or other interpreter joins a session as a translator, the staff who writes the PN will use Contact Type P (Telephone Spanish) or S (Face-to-Face Spanish), because the service was provided in Spanish.

Department of Rehab (DOR)

Coordination with DOR or TMHA re vocational rehab is Case Management.

Document services in the DOR subunit for your site. When writing a Progress Note for coordination, use the Dept. of Rehab Coordination template instead of the BH Progress Note template. This template starts with this new information:

PURPOSE: Collaboration between San Luis Obispo County Behavioral Health Department’s (SLOBHD) Cooperative Program, Mental Health Liaison (Liaison), TMHA, and DOR.

診断レビュー

診断レビューには、専門医療サービスの医療必要性を決定するための重要な臨床情報が含まれています。その他にも、請求やCSIレポートに必要な情報も含まれています。診断を変更する場合や更新する場合は、新しい診断レビューを作成します。

すべてのクライアントには、ICD10コードで診断される診断レビューが必要です。ICD10コードは使用されているが、スタッフはDSM 5診断基準に従って診断を作成します。州内のDHCSが入っている診断と除外される診断のリストを公開しています。

共有MHとDAS

MHとDASがクライアントを共有する場合、同時に1つの有効でアクティブな診断レビューしか存在できない。そのため、MHとDASからサービスを受けるクライアントが診断レビューの記録を共有する場合に問題が生じることがあります。クライアントの臨床病症を正確に反映し、両方のMHとDASの文書化基準を満たし、クライアントの治療に対する各サーバーの請求/レポート関数をサポートすることが求められます。協力してクライアントが共有する診断を決定するための重要な役割を果たすことが必要です。

Anasaziは、DASの請求書で最高優先度の物質使用障害を同定し、Mental Healthで最高優先度の精神健康の診断を同定します。請求の目的として、どの診断が診断レビューで最初に列挙されても、それぞれのプログラムの第一または第二の優先度で含まれている診断があることを除いては、クライアントが共有する場合は重要です。
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 (Licensed DAS 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, no matter whether the diagnoses included or excluded.

A client must have an included diagnosis to receive post-assessment Specialty Mental Health Services. List all relevant diagnoses on the Diagnostic Review. A client may receive Specialty Mental Health Services for an included diagnosis even if an excluded diagnosis is also present.

Diagnostic Reconciliation
Anasazi brings forward all previously entered diagnoses to the current Diagnostic Review. As a result, a client could acquire multiple, sometimes conflicting diagnoses if staff add new diagnoses without ending those that are no longer applicable. Very few clients have an active ICD 9 diagnosis, but if they do the old diagnosis must be ended effective 9/30/2015.

Staff must review every active diagnosis for consistency each time a Diagnostic Review is completed. If diagnostic criteria continue to be met, the diagnosis remains active (no End Date is entered). Enter an End Date for every diagnosis that is no longer applicable. Do not delete!

Carefully evaluate multiple diagnoses within a class to determine if contradictory diagnoses exist. Often, rendering a specific diagnosis should result in ending 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. End the diagnosis of Unspecified Mood Disorder because Major Depression is a more specific diagnosis. The Begin Date for the diagnosis of Major Depression is the day it was rendered and the End Date for Unspecified Mood Disorder is the day before. If the dates overlap, billing may suspend until corrected.

Changing a Diagnosis
Document the client's working diagnosis in Anasazi on the Diagnostic Review. Formulations written in Progress Notes or other assessments do not change the Diagnostic Review. If a MD/DO/NP changes a diagnosis following an evaluation, for example, staff will update the Diagnostic Review to reflect the new diagnosis.

Diagnostic Review FAQs
1. How often must a Diagnostic Review be completed?
   - When first receiving services (crisis contact, intake assessment, PHF admission)
   - Whenever a change of diagnosis is indicated

2. Diagnostic Review Dates:
   - Assessment Date: The date entered when the Diagnostic Review is launched
   - Begin Date: The date each diagnosis was first rendered. The Begin Date must be on or before the date of any billable services.
   - Final Approval Date: The date the Diagnostic Review was Final Approved. Billing suspends until the Diagnostic Review is Final Approved. After Final Approval, services provided on or after the Begin Date stage for billing
   - **When changing a diagnosis, remember “End yesterday, begin today” or “No gaps, no overlaps”**

3. Who completes and signs a Diagnostic Review?
   Staff complete Diagnostic Reviews within established scopes of practice. See **Scope of Practice and Role Acronyms** for additional detail.

   - Physician, Psychologist, LCSW, LMFT, LPCC, and NP staff render and update the Diagnosis Review. Associates and Trainees in one of the above disciplines render diagnoses “under the direction of” their clinical supervisor.
   - PTs and LVNs cannot render a diagnosis, but can assist by documenting symptoms and behavioral observations (Business and Professions Code, Division 2 Chapter 10 Section 4502 b)

**Notes:**
- MD/DO/NP signature is **not needed** if another Approved Category of Staff signed a Diagnostic Review
- In many instances, the Diagnostic Review 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.
- A staff member who is qualified to render a diagnosis must only sign the Diagnostic Review form once. Mark the other signature lines “N/A”.

4. **What service codes are used to document completing a Diagnostic Review?**

   **Approved Category of Staff: Assessment**

   Other clinical staff: Case Management can be used for the process of collecting basic data (symptoms, behavioral observations, etc.), but only an Approved Category of Staff renders the diagnosis.

5. **When must staff list the supportive symptoms on the Diagnostic Review Form?**

   When supporting symptoms are listed on an Assessment, Assessment Update, or other clinical document, they do not have to be repeated on the Diagnostic Review. Write, “See Assessment dated xx/xx/2016 for detail” in the “Summarize symptoms …” text box. Any other time a Diagnostic Review is completed, the primary MH diagnosis must be justified in the “Summarize symptoms …” text box.

6. **How do I document Medical Conditions?**

   Medical conditions may be recorded on a Diagnostic Review in three ways. Only the General Medical Condition Summary Code is required.

   **A. Text Box: “Summarize relevant medical issues as they pertain to the presenting problem”**
   - Allows staff of any discipline 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. General Medical Condition Summary Codes**
   - Allows staff of any discipline to document the client’s report of medical problems in a general manner.
   - Does not imply that the staff member is making a medical diagnosis.
   - **Required** (CSI reporting element)
   - If “99” Unknown/Not Reported General Medical Condition or “00” No General Medical Condition are selected, no other code may also be selected because the State CSI
computer system is programmed to reject inconsistent/illogical answers (How can “Unknown” be paired with something that is known? How can “None” be paired with another value?) If used, 99 and 00 can each only be the lone GMC.

C. Specific ICD10 Diagnoses entered in the Disorders and Conditions Multiple Entry Window
   • Allows staff of any discipline to record specific ICD10 medical diagnoses previously given to a client by his/her 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)

7. **What about Psychosocial and Contextual Factors?**
   • Psychosocial factors are entered in a separate table
   • Psychosocial factors are optional, but helpful in understanding the client’s history and challenges

8. **What does “SMI/SED Status” mean?**
   - “SMI” = Serious Mental Illness. This is a state reporting element that applies to any adult (18 and over) who has an included diagnosis and a significant functional impairment. SMI is similar to, but less strict than Medical Necessity criteria. Adults who meet Medical Necessity criteria also meet SMI criteria.
   - “SED” = Serious Emotional Disturbance. This is a state reporting element that applies to any youth under age 18 who has an included diagnosis and a significant functional impairment. SED is similar to, but less strict than Medical Necessity criteria. Some youth qualify for services due to “a reasonable probability that they will not progress developmentally as individually appropriate” without current functional impairments, but most youth clients who meet Medical Necessity criteria also meet SED criteria.

9. **How is “Experienced Trauma” defined?**
   “Experienced Trauma?” is a state reporting element. A “Yes” answer does not automatically imply that the client experiences any difficulties related to the trauma (e.g., PTSD). Trauma includes:
   - Witnessing or being a victim of crime or violence
   - Living through a natural disaster
   - Witnessing or being a combatant or civilian in a war zone
   - Witnessing or being a victim of a severe accident
   - Witnessing or being a victim of physical, emotional or sexual abuse
10. What if there is a difference of opinion about a client’s diagnosis?
Members of the treatment team may have a difference of opinion, but it is in the best interest of the client that the team discusses and agrees on a unified diagnosis. SAT consultation and the policy titled Second Opinion will guide next steps.

![Treatment Plans: Development and Approval Process](image)

**TREATMENT PLAN FAQS**

- A valid and current TP, completed with client participation and agreement, is a legal and contractual requirement for ongoing outpatient treatment!

- Update the TP annually or more often if the client’s condition requires more frequent update

- Document the client's or parent/legally responsible person's participation in developing and agreement with the TP on the TP

- Refer to P&P 3.20 Authorization of Services and Medical Necessity for detail

**WORK FLOW**

<table>
<thead>
<tr>
<th>ISL</th>
<th>Assessment Initial TP</th>
<th>New TP</th>
<th>Review TP</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Before walk-in, intake, or post PHF</td>
<td>• At kept walk-in screening, intake, or post PHF (or hospital)</td>
<td>• Add New TP to complete the first treatment-focused TP</td>
<td>• Review TP</td>
</tr>
<tr>
<td>• If needed for FTS, Crisis, MAA, or &quot;open / close / refer&quot;</td>
<td>• Use Assessment Initial TP Formatting Guide; needs little editing</td>
<td>• Fully personalized</td>
<td>• Lasts up to 1 year.</td>
</tr>
<tr>
<td></td>
<td>• Lasts up to 90 days</td>
<td>• Lasts up to 1 year</td>
<td>• Review to complete the second treatment-focused TP</td>
</tr>
<tr>
<td></td>
<td>• Final Approve and end if client does not follow up or if treatment ends</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INTERIM SERVICE LOG (ISL)**
An ISL allows staff to write Progress Notes to document a missed first appointment or contacts that occur prior to an intake, walk-in screening, or post hospital follow-up appointment (For
example, if a Case Manager visits a client on the PHF to plan for aftercare). An ISL may also be used when the result of the assessment is a referral to Holman Group or other open/close/refer scenarios. Use an ISL to write progress notes for MAA Crisis and Crisis Intervention for clients who are not open for other services, too. If you open an ISL, remember to enter an end date, too!

**ASSESSMENT INITIAL TP (AITP)**
We prepare a brief Treatment Plan (TP) when a client first enters treatment that allows us to quickly begin providing services that must be on a TP. This AITP must meet all the same requirements as any other TP, see below. New clients entering outpatient services participate in developing a short-term stabilization AITP at intake, walk-in screening, or post hospital follow-up appointment. Several customized AITP formatting guides allow staff to create the TP for the first 90 days of treatment.

**TREATMENT PLAN (TP)**
Overview of Required Elements

**Goals/Objectives:**
- Must be observable and/or quantifiable
- Must logically link with functional impairments that result from the diagnosis

**Proposed intervention(s)**
- Must address the functional impairments that result from the diagnosis
- Must be consistent with the diagnosis
- Must be consistent with/linked to the Goals/Objectives
- Must list of specific types/modalities of treatment
- Must include a detailed description of what staff will do
- Must include proposed frequency and duration of intervention(s)
- Must include an expected end date UNLESS the end date is the end of the TP

**Assessment Initial TP**
**Walk-in Screening or Assessment:**
When a client keeps a walk-in screening or assessment service, the clinician will discuss with the client the services the client requests for an initial stabilization period. The discussion will help the client understand the risks/benefits of treatment and the services available to help. The clinician will obtain the client’s input and agreement with the proposed initial services and objectives. If the clinician is not certain whether the client’s condition will require Specialty Mental Health Services (SMHS) or Holman level services, it is best practice to describe both processes and reassure the client that the clinician will link the client to the level of care that will best meet the client’s needs.
The clinician will:

- Launch a TP and will import the Assessment Initial TP formatting guide that matches the program (Adult, Youth, Martha’ Place, etc.). The formatting guide contains the most commonly used services that will allow an initial stabilization period with a proposed frequency, duration, and narrative that will meet most needs.
- Add or delete Interventions from the formatting guide to match the client's request and the services proposed by the clinician for the initial stabilization period
- Modify Dates to end the TP in **90 days**
- Document the client's participation in developing the plan using the “Document Client non-signature” option
- Electronically sign and route the TP to the Clinical Supervisor (when co-signature needed) or Program Supervisor (when no clinical co-signature is needed)

Click **How to Launch and Create an Assessment Initial TP using a Formatting Guide** for additional detail about the Anasazi process.

**Urgent Post PHF/Hospital Follow-up:**
When a client who was not previously open for outpatient services attends a post PHF/hospital follow-up appointment, staff will complete screening and provide needed services to ensure continuity of care. This may include arranging for a medical staff member to refill medications, scheduling an MD assessment for medication, and scheduling a comprehensive intake assessment with a clinician. Click **Urgent Services/Post PHF Follow Up** to see more information about post hospital documentation. Already-open clients who step down from a hospital to outpatient services will meet with their current team for follow up within seven days of discharge.

Staff who complete post hospital screenings for new clients will follow all the steps bulleted above to create a TP using the Assessment Initial TP formatting guide. “Approved category of staff” (therapists and MD/NP staff) must authorize routine services by signing the TP. Often, a Psychiatric Technician (PT) or a Licensed Vocational Nurse (LVN) will complete the post hospital screening, and, in an urgent situation such as a hospital follow up, will sign the TP. PT or LVN signature will authorize (make billable) the following urgent services:

- **Crisis Intervention** (not included on TP and does not need authorization)
- **Assessment, Plan Development** (these services do not require authorization but are on the TP formatting guide for consistency and to make it easier to write Progress Notes)
- **Case Management** or **Intensive Care Coordination** (each progress note must specifically state that the service is to link or refer a client to a needed services, including medical, social, educational, mental health, or substance use treatment services; cannot be the monitoring function of CM or ICC)
- **Medication Support** (each progress note must specifically say that there is an urgent
An approved category of staff must sign the Assessment Initial TP after an urgent screening by a PT or an LVN to authorize other routine services. The therapist who completes the assessment or the Program Supervisor will sign. The Program Supervisor will Final Approve the TP.

Authorization/Final Approval of the Assessment Initial TP
When the client's participation/agreement are documented on the TP AND an approved category of staff signed the Assessment Initial TP, all services listed in the TP, not just the ones listed above, are claimable. The Program Supervisor or designee will review the TP with the Assessment, sign, and Final Approve.

Closing the Assessment Initial TP
When a client withdraws from treatment during the period covered by the Assessment Initial TP and efforts to engage the client in treatment are not successful, the SAI will complete a Discharge Summary. The Program Supervisor will sign the TP (if not already completed). The site HIT will modify the end date to match the Discharge Summary and Final Approve the TP (if not already completed).

New TP
Prior to the expiration of the Assessment Initial TP or prior to initiation of FSP, Wraparound, IHBS, TBS, Day Treatment, or other intensive service, staff must end the Assessment Initial TP and create a new, more personalized TP. Add “New TP” rather than Review or Revise because all the Planning Tiers in the Assessment Initial TP focus on stabilization, not ongoing treatment. A member of the treatment team, usually the SAI, will meet with the client to develop a new TP. Staff will launch Assessment Initial TP, end it, and launch a new TP. Click How to End an Assessment Initial TP and Create a New TP to see how to do this in Anasazi. No elements from the previous TP will import – you must add and personalize each element! A formatting guide will make this easier. See Guidelines for Completing Planning Tiers (below) for more detail.

Review TP
When the first fully personalized TP nears expiration or when the client's condition changes, staff will update the TP. Review is the best option in Anasazi. A TP Review:

- Involves a comprehensive look at all Interventions and progress made by the client
- Establishes a new annual End Date for the

Add “New TP” is required. The Assessment Initial TP focused on stabilization, so start over to replace all the Planning Tiers!
Treatment Plan

- A TP Review should be completed when:
  - When the TP needs to be updated for the next review period
  - When New Goals, Objectives or Interventions are needed

  **Note:** Use the Revise TP very sparingly, if at all!

Click **How to End an Assessment Initial TP and Create a New TP** to see how to do this in Anasazi. The primary difference between Review and Add New is that previous Planning Tiers do import into the Review TP. Staff merely update to make the TP current.

**Guidelines for Completing Planning Tiers (applies to New TP and Review TP)**

- Remember to keep the TP simple and usable for the client!
- Only add Goals and Objectives as needed to meet the client’s treatment needs.

**STRENGTHS:**

- Option One: Select Strengths from the list. Planning Tier Narrative is optional
- Option Two: Select “In Client’s or Family's Own Words” from the selection list and quote the client/family in the Planning Tier Narrative. Planning Tier Narrative is required.
- Add the Strength “Helped to make and plan goals” to the TP to describe the involvement of the client and/or legally responsible person. Use a Formatting Guide to automatically add this Strength to the TP, or add it manually
- Strengths are qualities useful in helping the client attain TP goals

**FOCUS OF TREATMENT:**

- Planning Tier Narrative is required. Follow the prompt to help establish medical necessity.
- Symptoms should be a cluster (e.g., depression) rather than an exhaustive DSM list.
- Functional impairment must be clearly stated and explicitly linked to symptom cluster (e.g., “Depression results in inability to meet basic needs and maintain employment”).

**GOALS:**

- Positive Coping or Functional Impairment
• Goals restate the *functional impairment* in a broad manner and guide treatment in reducing the impairment
• Planning Tier Narrative is *optional*
• Select Goal(s) that match the functional impairment documented in the Focus of Treatment Planning Tier Narrative. This helps establish a clear link between the impairment and the Goal (e.g., if the impairment is school related, select “Improve School Functioning” as a goal).
• Select only the Goals that will be an active focus of treatment – keep the plan as simple as possible
• One Goal is sufficient if that is what fits for the client

**OBJECTIVES:**

*What will the client do?*

♠ **Personalized**

♠ **Measurable or Observable**

♠ **Linked to Goal**

- Planning Tier Narrative is *required*
- The Planning Tier Narrative is where the Objective is personalized, made observable or measurable, and directly linked to the Goal
- Select only those Objectives that are an active focus of treatment – keep it simple!
- Select Objectives that allow Interventions to clearly and logically link

The Objective “Utilize Medication Management” is very narrow and limited. Plan Development, Medication Support, and Evaluation & Management (only used by MDs) are the only interventions that now link to “Utilize Med Management.” Link Therapy and Rehabilitation services to an Objective that makes logical sense for the services.

Similarly, Medication Support does not logically link to a therapy/rehab objective like “Express feelings regarding trauma”. Medication Support may be linked to any Objective that allows a logical link, such as “Reduce Frequency/Intensity of Symptoms”, “Learn/Use Skills Needed to Take Medication as Prescribed”, and “Maintain Safe/Stable School Placement”.

**INTERVENTIONS:**

*What will staff do?*
- An Intervention is what staff will do to help a client accomplish an Objective
- Multiple Interventions may be linked to an Objective, but only if each links logically to the Objective
- Add Assessment and Plan Development once – any Objective will work
- Planning Tier Narrative is required for all Interventions, and must include a detailed description of the intervention to be provided

Click here to view Sample Planning Tier Narratives

**Notes on Frequency and Duration:**

**Frequency**
- Frequency is required, and equals the average number of proposed sessions (Monthly = 1 session per month; 3 times per week = 3 sessions per week)
- Do not use “Ad Hoc” as a frequency; instead, make a reasonable estimate

**Duration of sessions**
- Duration in Anasazi is an estimate of the typical length of each proposed service (Duration = 1 hour = hour long sessions, on average)
- This is a proposal, not a hard capacity limit
- If you consistently use more time than the proposed listed in the TP (either frequency or duration), update the TP to better match actual use
- For some services, such as Psychological Testing, the total duration of the service is more important than the length of each session. Frequency = Once; Duration = 7 hours is a better choice than attempting to estimate the number of testing, scoring and write up sessions needed to complete a Psychological Testing report, as long as the Intervention Planning Tier Narrative describes the action.

**Duration of Treatment**
- Duration of treatment is the length of time (days, weeks, months) you estimate the Intervention, Objective, Goal, or Focus will be active
- Set a Target Date for services you expect to be less than the duration of the TP. For example, if you are providing a 15-session structured group, estimate when the group will end and set a Target Date. You will not be able to provide the Intervention after the Target Date passes without updating the TP.
- Otherwise, leave Target Date blank
- Interventions are valid for the entire duration of the TP unless a Target Date specifies a shorter duration

Click How to End an Assessment Initial TP and Create a New TP to see more information about Planning Tier details: Established Date, Status, Status Date, Target Date, Frequency, Duration, Quantity, Anticipated Start, Unit, Subunit, and Server.
Treatment Plan Signatures

TP Signature Legal Requirement:
(2) Documentation of the beneficiaries’ participation in and agreement with their client plans...
(A) The MHP shall obtain the beneficiary's signature or the signature of the beneficiary's legal representative on the client plan when:
1. The beneficiary is expected to be in long term (one year for SLOBHD) treatment as determined by the MHP and
2. The client plan provides that the beneficiary will be receiving more than one type of specialty mental health service.
(B) When the beneficiary’s signature or the signature of the beneficiary's legal representative is required on the client plan under Subsection (d)(1) and the beneficiary refuses to sign the client plan or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability. (Title 9, 1810.440 (c)(2)(A and B)

Participation and Agreement
Staff must document a client's participation in developing and agreement with the TP. In certain cases, a parent's or legally responsible person's agreement replaces the client's; at other times, we need both. The best way to document participation in development and agreement with a TP is by obtaining a signature on the TP. When a person refuses or is not available to sign, a written explanation that describes participation, agreement, and explains why a signature is missing will meet the requirement and will allow staff to provide the services on the TP and bill for them. If you document participation and agreement on the TP using “Document Client Non-signature”, you may, but do not have to repeat this information in a Progress Note.

Adult Clients:

LPS conservatees
• An LPS conservatee's signature is optional. Use the “Document Client Non-signature” option to write a brief explanation for the missing signature.
• Evidence of the LPS conservator's participation in developing and agreement is required prior to delivering or billing for ongoing services. Add a signature line for this signature (Legally Responsible Person). If the conservator is the Public Guardian, obtain the signature.

Other adult clients
• Evidence of client’s participation in developing and agreement with the TP is required prior to delivering or billing for ongoing services. **Staff will obtain the client’s signature unless the client is unavailable or refuses to sign.** Staff must document participation and agreement – it is not sufficient to develop a TP and then tell the client what the objectives are.

• If an adult client is unavailable for signature at the time the TP is developed or refuses to sign the TP:

  ✓ Select “Document Client Non-signature” and state the reason for the absence of signature in the text box. Add a statement to describe the client’s participation in developing the TP and agreement with it.

  ✓ It is best practice, but not required, to obtain the client’s signature at the next face-to-face visit and to offer a copy of the signed TP to the client.

  ✓ Add a new client signature line and obtain the client’s electronic or hard copy signature. Do NOT edit or delete the signature box that contained the explanation of non-signature! Adding a new signature line allows the non-signature explanation reason, date, and time to remain a part of the TP, which is a requirement for billing services. Final Approve **after** the client signs or if the client refuses to sign the TP.

**Youth Clients:**
Staff must document a youth client’s participation in developing and agreement with the TP, but the requirements vary depending on the age of the client and the circumstances. The table below summarizes youth and Parent/Legally Responsible Person (P/LRP) documentation of participation and agreement with TP requirements. The best way to document participation and agreement is by obtaining signature on the TP. A detailed explanation is below the table.

**Note:** Table below presumes that a P/LRP signed Consent for Treatment (except Minor Consent)!

<table>
<thead>
<tr>
<th>Minor less than 12</th>
<th>Minor ≥ 12, not mature enough to participate in planning</th>
<th>Minor ≥ 12, mature enough to participate in treatment planning independently:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor &lt;6: Not Obtained</td>
<td>≥6: Not Required</td>
<td>Not minor consent</td>
</tr>
<tr>
<td>Best Practice</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>

“PC to Johnny to discuss new TP. He gave input into objectives and asked to continue med support and therapy. He agrees with TP and will sign it next week.”
Youth Client Signature:

- Minor under age 12:

Staff rarely obtain signature of a minor less than 6. Use the “Document Client Non-signature” option to write a brief explanation for the client’s absent signature. “Too young to sign” is an adequate explanation.

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. Explain the TP to the client in language the client can understand, and encourage the minor to sign unless clinically contraindicated. Use the “Document Client Non-signature” option to write a brief explanation for the client’s absent signature, if not obtained. “Client agreed with explanation of plan but did not sign” is an example.

- Minor 12 or older:

If a minor age 12 or older is mature enough to participate intelligently in treatment planning, staff must document client participation and agreement with the TP. Staff will obtain the client’s signature unless the client is unavailable or refuses to sign.

Use the “Document Client Non-signature” option to write a brief explanation for the client’s absent signature, if not obtained. It is best practice, but not required, to obtain the client’s signature at the next face-to-face visit. If staff obtain signature at a next session, add a new client signature line and obtain the client’s electronic or hard copy signature. Adding a new signature line allows the non-signature explanation reason, date, and time to remain a part of the TP.

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 to describe the specific behaviors that support the need for treatment despite the minor’s lack of participation with the TP or refusal to sign it. Staff may provide services without the youth’s signature or participation on the TP with only the P/LRP signature the TP in this instance.

Example:
“Client’s ongoing thought disturbance and unrealistic beliefs about her ability to care for herself...”
make her incapable of making intelligent, independent treatment choices. Without treatment, she is highly likely to deteriorate to a point where acute care is required to meet her needs. Her parents are in agreement with the TP, evidenced by their signature below.”

Final Approve the TP after the P/LRP signs, but continue to try to engage the minor in treatment and to develop an agreed upon TP. Document your efforts in your Progress Notes. Review the TP and document the minor’s agreement with the TP when the minor is able to participate meaningfully.

**Parent/Legally Responsible Person (P/LRP) Signature:**

Staff will obtain evidence of P/LRP participation in developing and agreement with the TP prior to delivering or billing for post-assessment services for minors under 12. Staff are strongly encouraged to obtain evidence of P/LRP participation in developing and agreement with the TP for minors 12 and older, minor consent services excepted.

Staff will obtain a signature as evidence unless the P/LRP is unavailable. If a P/LRP is unavailable for signature (for example, if staff develop the TP during a phone call to the parent):

- Document their agreement with and participation in the development of the TP on the TP by adding a **Client** signature line and documenting non-signature. Click [How to Document Client (and Parent) Participation and Agreement Using “Document Client Non-Signature”](#) to see detail about how to complete this step. Remember that you must document participation and agreement – it is not sufficient to develop a TP and then tell the parent what the objectives are.

- It is best practice, but not required, to obtain the P/LRP's signature at the next face-to-face visit and offer a copy of the signed TP. Add a new P/LRP signature line so the original non-signature explanation remains on the TP!

If the P/LRP is not actively involved in treatment with the minor aged 12+, after documenting participation and agreement on the TP as described above, make reasonable efforts to obtain P/LRP participation in treatment. Document the results in Progress Note(s). Examples of reasonable efforts include the following:
- Offer to set up home, school, or office visits with the parent
- Call the parent to discuss TP

“I spoke with parent by phone to develop TP. Parent participated and agreed with TP. Mother requests an increase in IHBS hours to help reduce client aggression toward sister. Will obtain signature at next week’s CFT meeting.”
For a minor under 12 or not mature enough to participate in treatment planning, no P/LRP participation and agreement = no treatment!

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 or on the TP. Program Supervisor approval is required for Minor Consent services.

Click for more detail: Minors in Treatment (Consent, TP and Authorization signatures)

Staff Signatures:
Clinician: The staff who develops the plan with the client always signs and dates the plan when completing it. This may be before the client signs the TP. If the clinician is an Approved Category of Staff, the signature authorizes the services. **REQUIRED**

Approved Category of Staff: An Approved Category of staff signature authorizes the services on the TP for billing, effective the date of the signature. This group includes any: Physician, licensed/waivered Psychologist, LMFT/LCSW/LPCC, registered MFT Intern, registered Associate Clinical Social Worker (ASW), registered PCCI or RN. On 1/1/2018, PCCI and MFTI will change to RAPCC and RAMFT, respectively. “Registered” means enrolled with the appropriate California licensing board and assigned (not awaiting) an intern number. “Waivered” refers to a DHCS-issued Professional License Waiver and only applies to psychologist candidates and LMFT, LCSW, and LPCC staff recruited from out-of-state awaiting licensing examination in CA. **REQUIRED**

Clinical Supervisor: Co-signature is required for all Registered Associates until waivered by SLOBHD and for all Trainees throughout the course of the traineeship. Clinical Supervisors may elect to co-sign select TPs for waivered Associates on an individual basis. Clinical Supervisor signature meets the Approved Category of Staff requirement. **DELETE IF NOT NEEDED**

MD/DO/NP: An MD/DO/NP signature is only required on TPs for clients covered by Medicare. Right click and select ‘delete’ to remove the MD signature line for all other clients. (MD doesn’t need to sign the TP to authorize med support). **DELETE IF NOT NEEDED**

Program Supervisor: A Program Supervisor signs and Final Approves each TP. If the Program Supervisor is in an approved category, his/her signature meets the requirement. **REQUIRED**

Signature lines for others may be added as the need arises (e.g., TMHA/FCN staff, SAI if TP developed by another provider).
**Treatment Plan Dates**

The *Begin Date* of a Treatment Plan is typically the date of the collaboration with the client to develop the plan. If you add a new TP or review a TP, end the previous TP the day before, so all the services on the new TP are effective as soon as an Approved Category of Staff signs the TP.

The *Approval Date* is the date the Approved Category of Staff signs the TP, which authorizes the services on the TP. Services that need authorization on a TP are billable as soon as the Approved Category of Staff signs and the TP contains evidence that the client participated in developing and agrees with the TP, as described above.

**Reminder:**

Write a Plan Development Progress Note when developing a new TP!

**TP Collaboration with CBOs**

The SAI is ultimately responsible for developing a TP that meets the client’s needs and accurately reflects the services provided. When MH and a CBO both provide services, the SAI may develop the TP personally or delegate responsibility to CBO staff for all or part of the TP, depending on what best serves the client.

- MH and CBO staff will discuss and agree upon all changes
- CBO staff can make any agreed-upon changes

**Note:** When CBO staff (e.g., at FCN or Kinship Center) serve as the SAI, the signature of the CBO’s Approved Category of Staff sets the *Approval Date* for billing, even when MH Program Supervisor signature is also required for Final Approval.

**Treatment Plans in Spanish**

Clients who prefer to receive services in Spanish will receive a TP written in Spanish and English. Bilingual staff create a TP in Anasazi using the English-language planning tiers and personalize Tier Narratives in English according to the instructions above. In addition, bilingual staff or Promotores interpreters translate the Planning Tier and any personalized text in each Tier Narrative text box. It is important to write the TP in English and Spanish in Anasazi, as the Spanish translation is proof that the client/parent agreed to the TP their primary language. Bilingual staff translated all Strengths, Focus of Treatment, Goals, Objectives and Interventions, which are available for use. Several Formatting Guides are pre-translated.

**Reminder:**

Services provided in Spanish, whether by clinical staff or interpreter, are coded with Contact Type “S” (Face-to-face Spanish) or “P” (Telephone Spanish).
When Completed:
When SAT approves ongoing services and treatment later ends, staff will complete a MH Outpatient Discharge Summary. A discharge summary is not needed when the SAT denies services when reviewing the initial intake assessment (“Open/Close”) – the SAT's decision is documented on the intake assessment. Assignment changes within a unit or referral to another Mental Health program, including to a Network Provider, are not discharges (see Transfer process, below).

Notes:
• A face-to-face or telephone contact to discuss the SAT's reasons for denying services is part of an "Open/Close". No discharge summary required!
• When clinic services close and the client will remain in therapy with a Network Provider, clinic staff will write a Transfer Progress Note to document the closing of clinic services and will route the note to the Managed Care Program Supervisor by adding a signature to the note. No discharge summary required!

Documentation Requirements:
1. A clinician, usually the SAI, summarizes treatment and documents any discussions regarding closing with client, Psychiatrist, Program Supervisor, or DAS (if applicable) on the MH Outpatient Discharge Summary. Staff complete the MH Outpatient Discharge Summary as fully as possible (all required fields, including Discharge Date at minimum).

2. Document contact attempts with the client on the Discharge Summary if the TP is expired. Do not add an ISL for progress notes when attempting to contact the client prior to closing, especially for leaving messages, which are not billable.

Note: Writing a discharge summary is not a billable service – no TP or Progress Note is required

3. The clinician routes the MH Outpatient Discharge Summary to:
   a. MD/DO/NP for signature (only if the client is taking medication)
   b. Program Supervisor for approval

4. The Program Supervisor reviews, signs, and then routes the MH Outpatient Discharge Summary to the HIT to process the closing.

5. The HIT:
a. Reviews the MH Outpatient Discharge Summary. If required fields are blank, the HIT routes the MH Outpatient Discharge Summary back to the clinician for completion.
b. Closes all MH assignments and the Treatment Session (if not still open to DAS).
c. Ends any open MH ISL, ITP or TP.
d. Pulls and processes the paper record.
e. Forwards the paper record to Central Medical Records for archiving.

<table>
<thead>
<tr>
<th>ID</th>
<th>Outpatient Discharge Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>MH Agree Tx Goals Reached</td>
<td>Use 32-34 when client and therapist agree to the closing (e.g. Client graduates from program)</td>
</tr>
<tr>
<td>33</td>
<td>MH Agree Tx Goals Part Reached</td>
<td>Use 33-34 when client and therapist agree to the closing (e.g. Client graduates from program)</td>
</tr>
<tr>
<td>34</td>
<td>MH Agree Tx Goals Not Reached</td>
<td>Use 33-34 when client and therapist agree to the closing (e.g. Client graduates from program)</td>
</tr>
<tr>
<td>35</td>
<td>MH Quit: Goals Part Reached</td>
<td>Use 35, 36 when client drops out or never showed up. (Includes AMA, AWOL, etc.)</td>
</tr>
<tr>
<td>36</td>
<td>MH Quit: Tx Goals Not Reached</td>
<td>Use 35, 36 when client drops out or never showed up. (Includes AMA, AWOL, etc.)</td>
</tr>
<tr>
<td>7</td>
<td>Deceased</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>MH Moved Out of Area</td>
<td>When client moves out of SLO County or area</td>
</tr>
<tr>
<td>38</td>
<td>MH Program Unilateral Decision</td>
<td>MH declines to treat, decides to close or transfer</td>
</tr>
<tr>
<td>8</td>
<td>Discharged/Transferred to Jail</td>
<td>Client is incarcerated</td>
</tr>
<tr>
<td>39</td>
<td>MH Unable to Locate Client</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>MH Age Ineligible</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

 Scholarship

Reopening

Reopening with 90 days of closing:

HIT:

See current HIT reopening procedure for additional detail

1. Edit the Treatment Session to delete the Date Closed, as this is the same episode of care
2. Open new Assignments if any will change; reopen previous assignments if continuing
3. Original Consent for Treatment and Acknowledgement of Privacy Practice are valid; Authorizations to Use/Disclose PHI are valid unless expired
4. Modify TP dates if the TP was shortened at closing (TP can never be longer than 365 days)

Clinician:

1. Complete an Assessment Update (Comprehensive assessment if none exists in Anasazi)
2. Write a Progress Note for the service
3. Update the Diagnostic Review (if needed; subject to scope of practice)
4. Obtain new Authorizations to Use Disclose as needed
5. Treatment Plan:
   a. Begin date is less than 1 year ago and all signatures are on the TP
      • Review with client
      • If Focus, Goal, Objectives, and Interventions are still relevant treatment will resume as authorized in the existing TP
      • Modify content if needed by completing a Review
      • Obtain new signatures when changing the TP or if any are missing
   b. Begin date is more than one year ago (TP expired)
      • Complete a new personalized, comprehensive TP (not an AITP) and obtain all signatures

Reopening more than 90 days from closing:

HIT and Front Office Staff: Follow new client opening procedures

Clinician:
1. Consult Managed Care or clinic Program Supervisor to determine whether to complete a new comprehensive assessment when one exists in Anasazi. In some instances, an Assessment Update will suffice – factors to consider include how recent the comprehensive assessment is and what has changed for the client since closing. In no instance will scheduling a comprehensive assessment delay timely access to services. If no comprehensive assessment exists in Anasazi, complete or schedule a new one.
2. Complete a new AITP
3. Write a Progress Note for the service
4. Update the Diagnostic Review (as needed and subject to scope of practice)

Transfer between Clinics or Programs

Whenever a client’s care transfers from one clinic (Unit) to another, take steps to ensure continuity of care. Examples of a transfer include:

- Transfer from North County MH to SLO MH because the client moved
- Transfer from BHTC to SLO MH when a client needs ongoing MH services
- Transfer from FSP to South County MH as a step down to a lower level of care.

Complete a BH Referral Form to make a Network Provider, Full Service Partnership or TMHA referrals. Do not complete a Transfer Summary, too. Similarly, when clinic services close, but a
Network Provider remains open, merely write a Case Management Progress Note to document the closing of clinic services. Add a signature to route the note to the Managed Care Program Supervisor, who will coordinate care with the Network Provider.

1. The Program Supervisor (or designee) at the site transferring the client consults with and obtains the agreement of the receiving site Program Supervisor (or designee) prior to transfer.
2. If the client is taking medication, the treating psychiatrist/NP must approve the transfer. Additionally, medical staff at the sending site must secure adequate medication refills and document this activity prior to transfer.
3. Using the Transfer Summary Progress Note Type and the Transfer Summary template, the SAI writes a Progress Note documenting the discussion with client, MD and Program Supervisor. The SAI must clearly document the reason for transfer, client’s treatment history, hospitalizations, response to medication, motivation, and any other relevant data, including risk factors. Bill time spent discussing and writing the Transfer Summary as Case Management for all clients. Add a signature to the note to route it to the HIT; electronic routing replaces a paper Client Update Form.
4. **The SAI must obtain updated contact information (new address and phone number) prior to transfer.** The HIT updates the Demographic and processes the transfer.
5. The transferring site HIT checks the record to make certain that all Progress Notes and assessments are Final Approved and that there are no “Past Due” notifications. Correct outstanding items prior to transfer unless the receiving Program Supervisor agrees to accept the transfer in an incomplete state.
6. The transferring site HIT closes assignments and opens an assignment at the receiving program (usually to the Program Supervisor at the receiving program in an Intake Subunit). This is especially important when transferring to a CBO provider who cannot add assignments. The HIT then forwards the physical chart to the receiving site and emails the receiving site Program Supervisor and HIT to alert them to the transfer to reduce missing or lost records.
7. The receiving site Program Supervisor reviews the record and makes treatment assignments at SAT, which the HIT enters from the SAT Log.
8. The new SAI reviews the record and meets with the client. If needed, the SAI completes an Assessment Update to document any important clinical information. Transfer is an ideal time to Review the Treatment Plan and make any needed adjustments based on the client’s needs/goals.
### Appendix A: Standard Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.A.</td>
<td>Alcoholics Anonymous</td>
</tr>
<tr>
<td>A.C.A.</td>
<td>Adult Children of Alcoholics</td>
</tr>
<tr>
<td>AH</td>
<td>auditory hallucinations</td>
</tr>
<tr>
<td>acct</td>
<td>account</td>
</tr>
<tr>
<td>ACH</td>
<td>American Care Home</td>
</tr>
<tr>
<td>ACTS</td>
<td>Abused Children's Treatment Services</td>
</tr>
<tr>
<td>AD</td>
<td>Alzheimer's disease</td>
</tr>
<tr>
<td>ADHD</td>
<td>attention deficit hyperactivity disorder</td>
</tr>
<tr>
<td>adj.</td>
<td>adjustment</td>
</tr>
<tr>
<td>ADL</td>
<td>activities of daily living</td>
</tr>
<tr>
<td>AF</td>
<td>afebrile</td>
</tr>
<tr>
<td>AG</td>
<td>Arroyo Grande</td>
</tr>
<tr>
<td>All</td>
<td>allergies</td>
</tr>
<tr>
<td>AMA</td>
<td>against medical advice</td>
</tr>
<tr>
<td>appt.</td>
<td>appointment</td>
</tr>
<tr>
<td>APS</td>
<td>Adult Protective Services</td>
</tr>
<tr>
<td>ARDS</td>
<td>adult respiratory distress syndrome</td>
</tr>
<tr>
<td>ARF</td>
<td>acute renal failure</td>
</tr>
<tr>
<td>ASA</td>
<td>acetylsalicylic acid (aspirin)</td>
</tr>
<tr>
<td>ASAP</td>
<td>as soon as possible</td>
</tr>
<tr>
<td>ASH</td>
<td>Atascadero State Hospital</td>
</tr>
<tr>
<td>assmt</td>
<td>assessment</td>
</tr>
<tr>
<td>asst</td>
<td>assist, assistance</td>
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<tr>
<td>ausc</td>
<td>auscultation</td>
</tr>
<tr>
<td>avg</td>
<td>average</td>
</tr>
<tr>
<td>AWOL</td>
<td>absent without leave</td>
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<td>AWS</td>
<td>alcohol withdrawal syndrome</td>
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<tr>
<td>Ax</td>
<td>axillary</td>
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<tr>
<td>B&amp;C</td>
<td>board and care</td>
</tr>
<tr>
<td>B.A., BA</td>
<td>blood alcohol</td>
</tr>
<tr>
<td>B.I.D.</td>
<td>2 times per day</td>
</tr>
<tr>
<td>B/D/F</td>
<td>Black divorced female</td>
</tr>
<tr>
<td>B/D/M</td>
<td>Black divorced male</td>
</tr>
<tr>
<td>b/f</td>
<td>boyfriend</td>
</tr>
<tr>
<td>B/M/F</td>
<td>Black married female</td>
</tr>
<tr>
<td>B/M/M</td>
<td>Black married male</td>
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<tr>
<td>b/o</td>
<td>because of</td>
</tr>
<tr>
<td>B/P</td>
<td>blood pressure</td>
</tr>
<tr>
<td>B/S/F</td>
<td>Black single female</td>
</tr>
<tr>
<td>B/S/M</td>
<td>Black single male</td>
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<tr>
<td>b/u</td>
<td>broke up, break up</td>
</tr>
<tr>
<td>BAL</td>
<td>blood alcohol level</td>
</tr>
<tr>
<td>bec</td>
<td>because</td>
</tr>
<tr>
<td>BHTC</td>
<td>Behavioral Health Treatment Court</td>
</tr>
<tr>
<td>BIB</td>
<td>brought in by</td>
</tr>
<tr>
<td>bilat</td>
<td>bilateral</td>
</tr>
<tr>
<td>bili</td>
<td>bilirubin</td>
</tr>
<tr>
<td>bldg</td>
<td>building</td>
</tr>
<tr>
<td>BPD</td>
<td>Bipolar Disorder</td>
</tr>
<tr>
<td>BPM</td>
<td>beats per minute</td>
</tr>
<tr>
<td>bro</td>
<td>brother</td>
</tr>
<tr>
<td>BS</td>
<td>blood sugar</td>
</tr>
<tr>
<td>BTL</td>
<td>bilateral tubal ligation</td>
</tr>
<tr>
<td>Bx</td>
<td>biopsy</td>
</tr>
<tr>
<td>C&amp;S, c&amp;s</td>
<td>culture and sensitivity</td>
</tr>
<tr>
<td>C.S.P.</td>
<td>coordination service plan</td>
</tr>
<tr>
<td>c/o</td>
<td>complaining of</td>
</tr>
<tr>
<td>C1-7</td>
<td>cervical vertebrae 1-7</td>
</tr>
<tr>
<td>Ca</td>
<td>calcium</td>
</tr>
<tr>
<td>CABG</td>
<td>coronary artery bypass graft</td>
</tr>
<tr>
<td>CAPD</td>
<td>chronic ambulatory peritoneal dialysis</td>
</tr>
<tr>
<td>cath</td>
<td>catheter or catheterization</td>
</tr>
<tr>
<td>Cauc</td>
<td>Caucasian</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioral Therapy</td>
</tr>
<tr>
<td>CD</td>
<td>chemical dependency</td>
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<tr>
<td>CDC</td>
<td>center for disease control</td>
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<tr>
<td>CDJC</td>
<td>child development center</td>
</tr>
<tr>
<td>cert</td>
<td>certification</td>
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<tr>
<td>CHC</td>
<td>Community Health Center</td>
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<td>chg</td>
<td>change</td>
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<td>cigs</td>
<td>cigarettes</td>
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<tr>
<td>circ</td>
<td>circulation</td>
</tr>
<tr>
<td>cl/dry</td>
<td>clean and dry</td>
</tr>
<tr>
<td>Clt</td>
<td>client</td>
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<tr>
<td>CM</td>
<td>case manager</td>
</tr>
<tr>
<td>CMC</td>
<td>California Men's Colony</td>
</tr>
<tr>
<td>CMV</td>
<td>cytomegalo virus</td>
</tr>
<tr>
<td>Co</td>
<td>county</td>
</tr>
<tr>
<td>COE</td>
<td>County Office of Education</td>
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<tr>
<td>Collat</td>
<td>collateral</td>
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<tr>
<td>comm</td>
<td>communication or community</td>
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<td>conc</td>
<td>concentrate</td>
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<td>cond</td>
<td>condition</td>
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<td>Conj</td>
<td>conjoint</td>
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<tr>
<td>conv</td>
<td>convalescent</td>
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<tr>
<td>Coord.</td>
<td>coordination (as in coordination team)</td>
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<tr>
<td>corresp</td>
<td>correspondence</td>
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<tr>
<td>CPR</td>
<td>cardiopulmonary resuscitation</td>
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<td>CPT</td>
<td>chronic paranoid type</td>
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<td>C-Section</td>
<td>caesarean section</td>
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<td>CWS</td>
<td>Child Welfare Services</td>
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<tr>
<td>Cx</td>
<td>cancel</td>
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<tr>
<td>CXR</td>
<td>chest x-ray</td>
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<tr>
<td>D&amp;A</td>
<td>drug and alcohol</td>
</tr>
<tr>
<td>D&amp;I</td>
<td>dry and intact (dressing)</td>
</tr>
<tr>
<td>d.o.e.</td>
<td>date of entry</td>
</tr>
<tr>
<td>D/O</td>
<td>disorder</td>
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<td>D/S</td>
<td>discharge summary</td>
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<td>due to</td>
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<td>DAS</td>
<td>Drug and Alcohol Services</td>
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<td>dbl</td>
<td>double</td>
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<tr>
<td>DBT</td>
<td>Dialectical Behavioral Therapy</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
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<td>--------------</td>
<td>-------------</td>
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<tr>
<td>FPC</td>
<td>family practice clinic</td>
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<td>Int. Med.</td>
<td>internal medicine</td>
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<td>IOP</td>
<td>intra-ocular pressure</td>
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<td>IR</td>
<td>ideas of reference</td>
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<td>IRB</td>
<td>institutional review board</td>
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<td>Irregular</td>
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<td>IUP</td>
<td>intrauterine pregnancy</td>
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<td>KCl</td>
<td>potassium chloride</td>
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<td>L.T. mem</td>
<td>long-term memory</td>
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<td>L/M</td>
<td>left message</td>
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<td>lac</td>
<td>laceration</td>
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<td>LCSW</td>
<td>Licensed Clinical Social Worker</td>
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<td>Li</td>
<td>Lithium</td>
</tr>
<tr>
<td>LiCO₃</td>
<td>Lithium carbonate</td>
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<td>NAR</td>
<td>no adverse reaction</td>
</tr>
<tr>
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<td>narcotic</td>
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<tr>
<td>NC</td>
<td>no charge</td>
</tr>
<tr>
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<td>North County Mental Health</td>
</tr>
<tr>
<td>NIDDM</td>
<td>non-insulin dependent diabetes mellitus</td>
</tr>
<tr>
<td>NKDA</td>
<td>no known drug allergies</td>
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<td>MI</td>
<td>myocardial infarction</td>
</tr>
</tbody>
</table>
Min/Min. Minimum/Minute
PD Police Department
Pd paid
PDA patent ductus arteriosus
PDD Pervasive Developmental Disorder
PDR physicians' desk reference
pers personality
PG public guardian
PH hydrogen ion concentration
Pharm.D. pharmacy doctor
PHF Psychiatric Health Facility
PHI protected health information
PHN Public Health Nurse
PI paranoid ideation
PKU phenylketonuria
PMD primary M.D.
PMS premenstrual syndrome
PO Probation Officer
PO phone order
pom by mouth
PP postprandial
pre before
preop preoperatively
prep preparation, prepare (for surgery)
PRN as needed
prog program
pro-time prothrombin time
PRS personal resource specialist
Psych psychiatric
Pt patient
PTSD Post Traumatic Stress Disorder
PTT partial thromboplastin time
pvt private
QAM in the morning
QD daily
QHS at hour of sleep
QID 4 times per day
QMHP qualified mental health professional
QPM in the afternoon
qt quart
R/O rule out
R/R rate & rhythm (speech)
R/S rescheduled
R/T related to
rbc red blood cell
Re recheck, regarding
Rec recreation
ref refer
PCP primary care physician
Rehab rehabilitation
rel relationship
Res. Tx. residential treatment
Ret'd returned
Retic reticulocyte
Rm room
RN Registered Nurse
RTC return to clinic
Rx prescription
S subjective
S&O salpingo-oophorectomy
s/sx signs/symptoms
SA suicide attempt
SAFE Systems Affirming Family Empowerment
sc subcutaneous
SC MH South County Mental Health Clinic
sched appt schedule appointment
Schiz schizophrenia
SDI state disability insurance
SE side effect
sec second, secondary
SED serious emotional disturbance
sem systolic ejection murmur
SI suicidal ideation
sib sibling
SIDS sudden infant death syndrome
sis sister
sit situation
SLCUSD San Luis Coastal Unified School District
SLO MH San Luis Obispo Mental Health Clinic
SLOCO Prob SLO County Probation Department
SLOPD San Luis Obispo Police Department
SLOSD San Luis Obispo Sheriff's Department
sm small
SMHS Specialty Mental Health Services
SNF skilled nursing facility
so significant other
SOB short of breath
SOC share of cost
Soc. socialization
Soc. Serv. social services
Sol, sol solution
sp spelling
spec specimen
spinal spinal anesthetic block
spont spontaneous
Spx specialist
### Appendix B: Service Indicators

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Person (Provided To):</strong> Who was present (in person or by phone) for the service or who was the service for?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Client with Family</td>
<td>Use ‘B’ if client is present with family in session.</td>
</tr>
<tr>
<td>C</td>
<td>Client</td>
<td>Use ‘C’ if client was present.</td>
</tr>
<tr>
<td>F</td>
<td>Family</td>
<td>Use ‘F’ if client not present with family. Define ‘family’ broadly. Includes foster, guardianship, adoption, caregiver or other living situations which the client considers ‘family’.</td>
</tr>
<tr>
<td>L</td>
<td>Legal Guardian</td>
<td>Use ‘L’ primarily for other legal representatives, i.e., conservators, court appointed representatives. If family members have legal guardianship and participate in session, choose B or F.</td>
</tr>
<tr>
<td>O</td>
<td>Other</td>
<td>Use ‘O’ if Social Worker, Probation Officer, teacher, etc. were present or if the service was on behalf of a client with nobody present (e.g. Plan Development without a client, report writing, etc.).</td>
</tr>
<tr>
<td>S</td>
<td>Other Service Provider</td>
<td>Use ‘S’ if other BH therapists, Group Home staff, FCN staff, etc. were present for the service without client.</td>
</tr>
<tr>
<td>T</td>
<td>Child and Family Team</td>
<td>ALWAYS use when you participate in a CFT and remember to choose ICC!</td>
</tr>
<tr>
<td><strong>Place (Provided At):</strong> CSI values formerly known as ‘location’. Select the place where you delivered the service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Office</td>
<td>Use if your office is at a BH site, including SAFE, etc.</td>
</tr>
<tr>
<td>B</td>
<td>Field (unspecified)</td>
<td>Services are provided away from usual place of business AND no other more specific choice applies.</td>
</tr>
<tr>
<td>C</td>
<td>Correctional Facility</td>
<td>Jail, not JSC. If JSC use ‘Y’.</td>
</tr>
<tr>
<td>D</td>
<td>Inpatient Psychiatric</td>
<td>PHF or other psychiatric hospital.</td>
</tr>
<tr>
<td>E</td>
<td>Homeless Shelter</td>
<td>Use if service was provided at a Homeless Shelter or Emergency Shelter.</td>
</tr>
<tr>
<td>F</td>
<td>Faith Based (church)</td>
<td>Primary Care MD's office, CHC, medical facility, medical hospital, Emergency Department, other medical care facility</td>
</tr>
<tr>
<td>G</td>
<td>Health Care – PCP Clinic</td>
<td>Client's home. Private residence where client receives services.</td>
</tr>
<tr>
<td>I</td>
<td>Age-Specific Comm Cntr.</td>
<td>Senior Center, daycare center, etc.</td>
</tr>
<tr>
<td>J</td>
<td>Client Job Site</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Res Care Facility - Aging</td>
<td>Skilled Nursing Facility, for example</td>
</tr>
<tr>
<td>L</td>
<td>Licensed Comm Care</td>
<td>Riverbed, park bench, etc. Will primarily be used by MHSA outreach staff.</td>
</tr>
<tr>
<td>O</td>
<td>Other Community Loc</td>
<td>Use this before choosing B</td>
</tr>
<tr>
<td>P</td>
<td>Phone</td>
<td>Use ‘P’ if service provided by phone, even if in office.</td>
</tr>
<tr>
<td>Q</td>
<td>Satellite</td>
<td>An office that is not at a certified site</td>
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<tr>
<td>R</td>
<td>Res Care Facility-Youth</td>
<td>Formerly RCL 13-14 group home, now STRTP</td>
</tr>
<tr>
<td>S</td>
<td>School</td>
<td>Use if you deliver services at a school</td>
</tr>
<tr>
<td>U</td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>MH Adult Residential</td>
<td>Board &amp; Care, Adult Placement</td>
</tr>
<tr>
<td>W</td>
<td>Group Home</td>
<td>RCL 10-12 – these no longer exist</td>
</tr>
<tr>
<td>X</td>
<td>SA Residential</td>
<td>Substance Abuse Residential including Sober Living</td>
</tr>
<tr>
<td>Y</td>
<td>Juvenile Center</td>
<td>JSC</td>
</tr>
<tr>
<td>Z</td>
<td>Unknown/Not Reported</td>
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<tr>
<td>S</td>
<td>Crisis Stabilization Unit</td>
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</table>
### Contact Type

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>C</td>
<td>Correspondence Letters, email, text – can be billable if a service was provided.</td>
</tr>
<tr>
<td>F</td>
<td>Face to Face A person (see Person above) is present for the service.</td>
</tr>
<tr>
<td>O</td>
<td>Other Billable consultations, Plan Development, etc. if no client present.</td>
</tr>
<tr>
<td>H</td>
<td>Telehealth Use if the service is provided by video connection</td>
</tr>
<tr>
<td>P</td>
<td>Telephone - Spanish Use if server or interpreter is speaking with a person in Spanish on the phone.</td>
</tr>
<tr>
<td>S</td>
<td>Face to Face - Spanish Use if server or interpreter is speaking Spanish face to face.</td>
</tr>
<tr>
<td>T</td>
<td>Telephone Billable if a service was provided, not billable if purely clerical.</td>
</tr>
<tr>
<td>V</td>
<td>Voice Mail Use if listening to or leaving a message (English or Spanish). Not billable.</td>
</tr>
<tr>
<td>X</td>
<td>Fax Not billable.</td>
</tr>
<tr>
<td>Y</td>
<td>TTY Communication device for hearing impaired clients.</td>
</tr>
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</table>

### Appointment Type

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<tbody>
<tr>
<td>1</td>
<td>Scheduled Scheduled = planned, broadly defined, even if appointments have no set time</td>
</tr>
<tr>
<td>2</td>
<td>Unscheduled / Walk-in Unexpected walk ins, unscheduled phone calls.</td>
</tr>
<tr>
<td>3</td>
<td>Cancelled by Client Not billable</td>
</tr>
<tr>
<td>4</td>
<td>Cancelled by Clinic Use if cancellation is due to clinician illness or absence</td>
</tr>
<tr>
<td>5</td>
<td>No Show Remember to zero out all time (service, travel and documentation)!</td>
</tr>
<tr>
<td>9</td>
<td>Unbillable Service</td>
</tr>
<tr>
<td>10</td>
<td>Cancelled due to Crisis Use if cancellation is due to a crisis to which the clinician must respond.</td>
</tr>
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</table>

### Billing Type: Provides an additional level of controls for billing MH services.

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<th>Code</th>
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<tr>
<td>I</td>
<td>Interactive Nonverbal communication method</td>
</tr>
<tr>
<td>N</td>
<td>No Valid Treatment Plan Use sparingly for services provided when treatment plan expired. Create a TP!</td>
</tr>
<tr>
<td>S</td>
<td>Standard Service All regular, planned services or services which don't require a plan</td>
</tr>
<tr>
<td>L</td>
<td>Late Entry Use for Progress Notes written more than 14 days after the service.</td>
</tr>
<tr>
<td>V</td>
<td>Voided Use when a claimed service is voided for a reason other than late entry or no medical necessity. Not billable.</td>
</tr>
<tr>
<td>D</td>
<td>Doesn't meet Medical Necessity Used when an audit determines that a Progress Note does not document medical necessity adequately to justify billing. Not billable.</td>
</tr>
<tr>
<td>P</td>
<td>Second Opinion Used when the Patient's Rights Advocate asks a clinician to perform a second opinion review.</td>
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### Intensity Type

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<td>C</td>
<td>Crisis: Within 1 hour Use only with Crisis Intervention or MAA Crisis service codes. Response time is within 1 hr. of the client's call in or walk in request for services.</td>
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<tr>
<td>D</td>
<td>Crisis/Urgent: Within 48 hours Use only with Crisis Intervention or MAA Crisis service codes, because crisis services do not require preauthorization.</td>
</tr>
<tr>
<td>U</td>
<td>Urgent: Within 96 hours (4 days) Use with any service other than Crisis Intervention or MAA Crisis. Other services require preauthorization. Days are calendar days.</td>
</tr>
<tr>
<td>P</td>
<td>Post Hospital Follow Up Use 'P' when the service is a post hospital (PHF or out-of-county) follow up.</td>
</tr>
</tbody>
</table>
| R    | Routine To providers other than MD or NP = within 10 business days of request
To an MD or NP = within 15 business days of request |
| S    | CSU                                                                          |
| F    | CSU Follow Up Use for all outpatient services scheduled as a follow-up from CSU |

### EBP/SS: Evidence Based Practices/Service Strategies

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<td>99</td>
<td>Unknown/Not Reported Default to this value.</td>
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# Appendix C: List of Service Codes, Services, and CPTs (Reviewed 2015)

## Mental Health Services

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<th>Description</th>
<th>CPT Code</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>MH Assessment</td>
<td>90791</td>
<td>MD, NP, DO, PhD, PsyD, LMFT, LCSW, Interns, Trainees</td>
</tr>
<tr>
<td>200</td>
<td>MH Case Management</td>
<td>90882</td>
<td>All Clinical Staff</td>
</tr>
<tr>
<td>201</td>
<td>MH Collateral Services</td>
<td></td>
<td>All Clinical Staff</td>
</tr>
<tr>
<td>203</td>
<td>MH Crisis Intervention</td>
<td></td>
<td>All Clinical Staff</td>
</tr>
<tr>
<td>204</td>
<td>MH Family Therapy (Client w/ family, family, legal guardian)</td>
<td>90846, 90847</td>
<td>PhD, PsyD, LMFT, LCSW, Interns, Trainees</td>
</tr>
<tr>
<td>205</td>
<td>MH Group Therapy</td>
<td>90853</td>
<td>PhD, PsyD D, LMFT, LCSW, Interns, Trainees</td>
</tr>
<tr>
<td>206</td>
<td>MH Individual Therapy</td>
<td>90832, 90834, 90837</td>
<td>PhD, PsyD, LMFT, LCSW, Interns, Trainees</td>
</tr>
<tr>
<td>207</td>
<td>MH Individual Rehab Interventions</td>
<td></td>
<td>All Clinical Staff</td>
</tr>
<tr>
<td>208</td>
<td>MH Group Rehab Interventions</td>
<td></td>
<td>All Clinical Staff</td>
</tr>
<tr>
<td>209</td>
<td>MH Multi-Family Group Therapy</td>
<td>90849</td>
<td>PhD, PsyD, LMFT, LCSW, Interns, Trainees</td>
</tr>
<tr>
<td>210</td>
<td>MH Plan Development</td>
<td></td>
<td>All Clinical Staff</td>
</tr>
<tr>
<td>220</td>
<td>Intensive Care Coordination</td>
<td></td>
<td>All Clinical Staff</td>
</tr>
<tr>
<td>221</td>
<td>Intensive Home Behavioral Services</td>
<td></td>
<td>CBO Clinical Staff</td>
</tr>
<tr>
<td>301</td>
<td>MH Medication Support</td>
<td>90862</td>
<td>MD, NP, DO, PA, PT, RN, LVN, Pharmacist</td>
</tr>
</tbody>
</table>

For E & M Codes, see MD documentation instructions

## MAA

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>CPT Code</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>414</td>
<td>MH MAA Outreach</td>
<td></td>
<td>All Clinical and Support Staff</td>
</tr>
<tr>
<td>415</td>
<td>MH MAA Elig Intake</td>
<td></td>
<td>All Clinical Staff</td>
</tr>
<tr>
<td>416</td>
<td>MH MAA Crisis Referral</td>
<td></td>
<td>All Clinical Staff</td>
</tr>
<tr>
<td>417</td>
<td>MH MAA SPMP Case Mgmt</td>
<td></td>
<td>MD, DO, NP, PA, RN, MSW, LCSW, LMFT, Licensed Psychologist</td>
</tr>
<tr>
<td>418</td>
<td>MH MAA Non-SPMP Case Mgmt</td>
<td></td>
<td>LPT, LVN, Reg. Associate, Trainee</td>
</tr>
<tr>
<td>442</td>
<td>MH MAA Contract Administration, Non-discounted</td>
<td></td>
<td>MH Division Managers, BH Administrator, Medical Director, BH Fiscal Staff</td>
</tr>
<tr>
<td>443</td>
<td>MH MAA Coordination/Claims Admin</td>
<td></td>
<td>All Clinical and Support Staff</td>
</tr>
</tbody>
</table>
### MH MAA SPMP Plan/Policy Develop

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>CPT Code</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>470</td>
<td>MH MAA SPMP Plan/Policy Develop</td>
<td>--------</td>
<td>MD, DO, NP, PA, RN, MSW, LCSW, LMFT, Licensed Psychologist</td>
</tr>
</tbody>
</table>

### MH MAA Non-SPMP Plan/Policy Develop

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>CPT Code</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>471</td>
<td>MH MAA Non-SPMP Plan/Policy Develop</td>
<td>--------</td>
<td>LPT, LVN, Reg. Associate, Trainee</td>
</tr>
</tbody>
</table>

### MH MAA Contract Administration, Discounted

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>CPT Code</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>480</td>
<td>MH MAA Contract Administration, Discounted</td>
<td>--------</td>
<td>MH Division Managers, BH Administrator, Medical Director, BH Fiscal Staff</td>
</tr>
</tbody>
</table>

### TBS: Contract TBS Providers, MH Staff completing TBS Assessments and Plans

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>CPT Code</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>500</td>
<td>MH TBS Assessment</td>
<td>--------</td>
<td>MH Clinical Staff – Psychologist, LMFT, LCSW, Reg. Associate, Trainees</td>
</tr>
<tr>
<td>501</td>
<td>MH TBS Plan Development</td>
<td>--------</td>
<td>CBO &amp; MH Clinical Staff</td>
</tr>
<tr>
<td>502</td>
<td>MH TBS Collateral</td>
<td>--------</td>
<td>CBO Clinical Staff</td>
</tr>
<tr>
<td>503</td>
<td>MH TBS Direct</td>
<td>--------</td>
<td>CBO Clinical Staff</td>
</tr>
</tbody>
</table>

### Testing

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>CPT Code</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>700</td>
<td>MH Psychological Testing</td>
<td>96101</td>
<td>MD, DO, Psychologist</td>
</tr>
<tr>
<td>701</td>
<td>MH Explain Results Resp Party</td>
<td>90887</td>
<td>Psychiatrist, Psychologist</td>
</tr>
<tr>
<td>702</td>
<td>MH Report Prep for Brokerage (JV220, SSI)</td>
<td>--------</td>
<td>All Clinical Staff</td>
</tr>
<tr>
<td>703</td>
<td>MH Diagnostic Eval/Reports</td>
<td>90885</td>
<td>Psychologist, LMFT, LCSW</td>
</tr>
<tr>
<td>704</td>
<td>MH Developmental Testing (includes MIM)</td>
<td>96110</td>
<td>MD, DO, Psychologist, LCSW, LMFT, Reg. Associate, Trainees (MIM only)</td>
</tr>
<tr>
<td>705</td>
<td>MH Developmental Testing-Ext</td>
<td>96111</td>
<td>MD, DO, Psychologist</td>
</tr>
<tr>
<td>706</td>
<td>MH Neurobehavioral Status Exam</td>
<td>96116</td>
<td>MD, DO, Psychologist</td>
</tr>
<tr>
<td>707</td>
<td>MH Neuropsychological Testing</td>
<td>96118</td>
<td>MD, DO, Psychologist</td>
</tr>
</tbody>
</table>
### Appendix D: Travel Time Billing Guidelines

Staff may bill for travel time only when time is linked to a MHS actually provided to a client.

<table>
<thead>
<tr>
<th>ALLOWED</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>From staff’s assigned Clinic or approved telecommuting site to ...</td>
<td>Client’s Home, or any setting in which the client is seen (other than Office). Can include return time to the clinic/telecommuting site.</td>
</tr>
<tr>
<td>From staff’s assigned Clinic or approved telecommuting site to ...</td>
<td>Inter-agency meetings, such as those for IEP, DSS, and Probation, in which Plan Development or other claimed MHS are provided to a client. Return time to the clinic/telecommuting site can be included in travel time.</td>
</tr>
<tr>
<td>From staff’s assigned Clinic site to ...</td>
<td>Out-of-county STRTP to provide MHS to one or more county youth. Time to return to clinic can be included in travel time.</td>
</tr>
<tr>
<td>From staff’s assigned Clinic site to ...</td>
<td>Out-of-county Board and Care to provide MHS to one or more county clients. Time to return to clinic can be included in travel time.</td>
</tr>
<tr>
<td>From staff’s assigned Clinic or approved telecommuting site to ...</td>
<td>Client A’s location. If you visit client A more than once in a day, travel time can be billed for these visits if each visit originated from staff’s assigned clinic or telecommuting site.</td>
</tr>
<tr>
<td>From Client A’s location to (a series of other clients on the same day)</td>
<td>Client B and Client C on the same day. Travel time is only allowed for time between Client A’s and Client B’s location, between B and C, etc. Include return time to clinic on last client visit of the day. Don’t include the return time to clinic if staff returns home from the last client visit.</td>
</tr>
<tr>
<td>From MHET initial dispatch point to ...</td>
<td>Client location.</td>
</tr>
<tr>
<td>From MHET client contact point to ...</td>
<td>PHF, or other location necessary in the process of resolving the crisis, such as hospital emergency room, mental health clinic, alternative secure housing, etc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NOT ALLOWED</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>From location A to ...</td>
<td>Location B for any non-billable service or for no service</td>
</tr>
<tr>
<td>(You arrive at a client’s home but he/she is not there.)</td>
<td></td>
</tr>
<tr>
<td>From staff’s home to ...</td>
<td>Mental Health Clinic or Other Office. (Other Office could be an office on a school site, a class room service site, an office co-located with DSS or Probation.)</td>
</tr>
<tr>
<td><em>Unless the staff has been approved to telecommute from home and this claimable service is provided on a date the staff is telecommuting.</em></td>
<td></td>
</tr>
<tr>
<td>From staff’s home to ...</td>
<td>Out-of-County STRTP to provide MHS to one or more county clients.</td>
</tr>
<tr>
<td>From staff’s assigned Clinic or approved telecommuting site to ...</td>
<td>An IMD to provide MHS to one or more county beneficiaries.</td>
</tr>
<tr>
<td><em>Note:</em> No services can be claimed for IMD residents while in IMD.</td>
<td></td>
</tr>
<tr>
<td>From staff’s assigned Clinic or approved telecommuting site to ...</td>
<td>Other Office such as an office on a school site, a classroom service site, an</td>
</tr>
<tr>
<td>or approved telecommuting site to ...</td>
<td>office co-located with DSS or Probation.</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Transporting a client from point A to point B</td>
<td>Transporting clients from their home and driving them to clinic is not a billable activity unless a service is provided.</td>
</tr>
</tbody>
</table>
Appendix E Medi-Cal Administrative Activities (MAA)

Definitions:
SPMP: Skilled Professional Medical Personnel: MD, PA, RN, LCSW, LMFT or Licensed Psychologist

Non-SPMP: LPT, LVN, Registered Associate, Trainee, or other Behavioral Health staff

Client: An individual is considered a “client” when the individual or representative (as with a minor) has signed consent for treatment and has an expectation of privacy.

Non-discounted: The term relates to the financial reimbursement and if the rate or percentage of reimbursement is discounted or not. Activities that strictly benefit Medi-Cal beneficiaries are considered “non-discounted” and paid at the full reimbursable rate.

Discounted: It is understood that some of the MAA activities may benefit individuals who are not Medi-Cal beneficiaries, so the reimbursement for those activities are “discounted” or reduced to factor in the non Medi-Cal individuals.

Documenting Medical Administrative Activities in Anasazi

MAA Crisis Referral
MAA Crisis Referral is an activity provided to a person who is not a MH client with the goal of referring the individual to MH (e.g., helping the recipient become a MH client).

- MAA recipients are logged into Anasazi by name (if available), but are not assigned a new Medical Record number. (If the recipient’s name is already in Anasazi with a record number, do not create a new record or change the existing number – use the existing record.)
- MAA recipients are assigned to the MAA subunit (2601) to allow the crisis worker to document the activity.

Click here to go to MH Crisis Intervention versus MAA Crisis Referral information

MAA Case Management
Definition:
1. Gathering information about an individual’s health and mental health needs
2. Helping individuals access Medi-Cal covered physical health and mental health services by providing referrals, follow-up, or arranging transportation for health care.

Use MAA Case Management to record time spent reviewing closed case records for Client Access or Third Party Disclosures!
### MAA Medi-Cal Outreach

**Definition of Medi-Cal Outreach – Not Discounted:**

Medi-Cal Outreach, Not Discounted is intended to assist individuals who are eligible or potentially eligible for Medi-Cal. Activities include:

1. Informing individuals who are eligible or potentially eligible about health programs, including specialty mental health services.
2. Assisting individuals who are at-risk and eligible or potentially eligible for Medi-Cal to understand the need for mental health services.
3. Actively encouraging individuals who are reluctant and eligible or potentially eligible for Medi-Cal to accept the needed mental health services and health services.

<table>
<thead>
<tr>
<th>Scenario:</th>
<th>Front Office Responsible for:</th>
<th>Clinician Responsible for:</th>
<th>Intervention Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAA Medi-Cal Outreach to a specific individual</td>
<td>• If not in Anasazi, complete Core Client Information (Index Card) as fully as possible. (Use 1/1/1800 if client can't/won't give a DOB.)&lt;br&gt;• Do <strong>not</strong> assign Medical Record #.&lt;br&gt;• Assign to staff member, Subunit 2601</td>
<td>• Interim Service Log&lt;br&gt;• Individual Progress Note (BH Progress Note template)</td>
<td>MAA Medi-Cal Outreach, Not Discounted (414)</td>
</tr>
<tr>
<td>MAA Medi-Cal Outreach to a group</td>
<td></td>
<td></td>
<td>MAA Medi-Cal Outreach, Not Discounted (414)</td>
</tr>
</tbody>
</table>

### MAA Case Management

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Front Office Responsible for:</strong></td>
<td><strong>Clinician Responsible for:</strong></td>
<td><strong>Intervention Code:</strong></td>
</tr>
<tr>
<td>• If not in Anasazi, complete Core Client Information (Index Card) as fully as possible. (Use 1/1/1800 if client can't/won't give a DOB.)&lt;br&gt;• Do <strong>not</strong> assign Medical Record #.&lt;br&gt;• Assign to staff member, Subunit 2601</td>
<td>• Interim Service Log&lt;br&gt;• Individual Progress Note (BH Progress Note template)</td>
<td>MAA SPMP Case Management (417) (LMFT, LCSW, Psychologist, RN)&lt;br&gt;MAA non-SPMP Case Management (418) (LPT, LVN, Reg. Associate, Trainee)</td>
</tr>
</tbody>
</table>
MAA Medi-Cal Eligibility Intake

Definition:
Medi-Cal Eligibility Intake is intended to assist individuals with the application for Medi-Cal benefits. This activity does not include the eligibility determination itself, but does include screening and assisting consumers of mental health services with the application for Medi-Cal benefits. This is the only MAA activity that may be provided to an open Mental Health client.

<table>
<thead>
<tr>
<th>Scenario:</th>
<th>Front Office Responsible for:</th>
<th>Clinician Responsible for:</th>
<th>Intervention Code:</th>
</tr>
</thead>
</table>
| MAA Medi-Cal Eligibility Intake | ▪ If not in Anasazi, complete Core Client Information (Index Card) as fully as possible. (Use 1/1/1800 if client can't/won't give a DOB.)
▪ Do not assign Medical Record #.
▪ Assign to staff member, Subunit 2601 | ▪ Interim Service Log
▪ Individual Progress Note (No template required) | MAA Medi-Cal Eligibility Intake (415)

*Note: Can be provided to an open client*
Appendix F: Void and Replicate
Client / Designee requests refill (phone or in person)

Pharmacy requests refill by fax

Fax requests given to Med Manager

Med Manager reviews client’s record

Tip: Review each of the client’s meds to synchronize refills!

Med Manager reviews client’s record

Refills left per AZ?

Med Manager collects:
- Date of client’s next visit with MD/NP (Schedules with client if needed)
- Date client last seen by MD/NP
- Date of last refill
- Other meds which might soon need refilled

Med Manager consults with MD/NP

MD/NP approves refill as requested?

Yes

MD/NP approves partial refill pending face-to-face visit?

Yes

No

Med Manager informs client, schedules follow up with MD/NP, and documents consultation in a Med Support note

No

MD/NP signs, Final Approves and transmits (or writes) prescription

Yes

Med Manager: For ALL prescription types (phone, written, electronic refill)

Med Manager:
- Prepares and preapproves script(s) in Anasazi
- Routes to MD/NP
- Informs client
- Documents consultation and refill in Med Support note.

No

Pharmacy fills/refills prescription

Med Manager: calls pharmacy to reconcile records

- Informs client of refill
- Schedules next MD/NP visit if needed
- Writes Med Support note

Yes

Med Manager collects:

- Date of client’s next visit with MD/NP (Schedules with client if needed)
- Date client last seen by MD/NP
- Date of last refill
- Other meds which might soon need refilled

Med Manager consults with MD/NP

MD/NP approves refill as requested?

Yes

MD/NP approves partial refill pending face-to-face visit?

No

Yes

No
Appendix H: Urgent Services/Post PHF Follow Up Procedure

Managed Care Staff Duties:
1. Collect referral information from PHF or hospital staff
2. Schedule post PHF follow up sessions with designated staff at each clinic (Intensity Type “Post Hospital Follow Up”)
3. Schedule comprehensive intake assessment after client keeps post PHF screening

Front Office Staff Duties:
When client arrives for post PHF screening, the Front Office staff will complete all standard intake paperwork with client per existing procedures:

1. Review and update (if needed) Demographic and be sure it is admitted status
2. Review and obtain client signature on Consent for Treatment (unless already in AZ for the current outpatient treatment episode)
3. Review and obtain client signature on Acknowledgement of Receipt of Privacy Practices
4. Collect Health History form; Developmental History for minors (optional at post PHF, required at intake)
5. Collect Cost Agreement
6. Collect ABN for Medicare clients

Clinician Duties:
When the client keeps the post PHF screening appointment, the clinician will:

1. Complete screening, complete safety check, etc., and document in a progress note per current policy
2. Update Form: Submit an update form to the site HIT to add any needed subunit and staff assignments for the first 60 days of urgent service (includes MD, med manager, etc.)
3. Schedule an intake appointment with an approved category of staff member in the clinic (if not already completed). Managed Care staff may be called to assist with scheduling
4. Schedule an appointment with an MD/NP (if clinically indicated/if the client is discharged from PHF or jail on medication). Do not wait for the comprehensive assessment to be completed before scheduling medication support
5. TP:
   - Start the Assessment Initial TP on the date of the first urgent service and then write a progress note (write all notes in the TP, unless the client is a FTS – then use an ISL)
   - Document the client’s symptoms and resulting functional impairment in the ITP, emphasizing the need for urgent treatment. Use your observations, the client’s self-report, and the PHF psychiatrist’s discharge note as sources.
   - Assign signatory to the Program Supervisor to route the TP for signature
   - The Program Supervisor or designee will Final Approve the TP.
6. All services provided pending the comprehensive assessment will use the Intensity Type “Urgent”.

7. Discharge/FTS:
   If the client hasn't been seen for any additional services between the post PHF screening and the date the Assessment Initial TP expires:
   • Make contact efforts per existing policy
   • If not successful in engaging client, complete an Anasazi Discharge Summary, complete an update form for the HIT, and close the case

**HIT Duties:**

1. **Urgent Services Client Category:** The clinic site HIT will set the Client Category start date from the date of the first urgent service (usually the post PHF screening date).

2. The clinic site HIT or approved AA will run the client assignment report and add the client category and provide to PS monthly to track all clients being provided urgent services.

3. The clinic site HIT will audit services on a monthly basis to ensure/correct Intensity Type as needed.
Post PHF Documentation Workflow

Did client keep first appointment?

Yes

No

Post PHF screener
- Complete service
- Explain services and TP to client
- Call Managed Care for intake appointment
- Launch Assessment Initial TP (AITP) and modify end date to 90 days
  (MC staff may agree to launch and end)
- Document client participation and agreement with AITP
  - Usually in non-signature text
  - May be by electronic signature
- Write Progress Note
- Schedule with MD/NP if needed
- Route AITP to assessing therapist (if post PHF clinician is a PT/LVN/RN)
- Route AITP to Program Supervisor

Assessing clinician
- Sign AITP right away
  (AITP signature authorizes ongoing services; you will recommend services in the Assessment)

Did client keep assessment appointment?

Yes

No

Assessing clinician
- Complete assessment
- Document your recommended services in Assessment
- Review AITP with client; ask client to sign (client signature is optional if non-signature already documented)
- Sign if an LPHA signature is needed
- You do not need to delete services because plans may change in the 90 day AITP period
- Progress Note in AITP

Program Supervisor
- Review AITP, sign, and assign staff
- Final Approve AITP after SAT

Assessing clinician
- Call client, reschedule if possible
- Progress Note in AITP
- Routing sheet/chart HIT for SAT log (tracks Urgent services)

Clinic staff (usually Med Manager)
- Call client, engage in treatment
- Reschedule assessment
- Keep MD appointment scheduled/schedule if needed
Appendix I: Record of Disclosure/Authorization to Use or Disclose PHI

Third Party Disclosures Initiated by a MH Qualified Professional

<table>
<thead>
<tr>
<th>Disclosure Scenarios:</th>
<th>Reference</th>
<th>Authorization to Use or Disclose PHI needed?</th>
<th>Record of Disclosure needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclosures for treatment purposes “...between qualified professionals in the provision of services or appropriate referrals…” when the professionals have “medical or psychological responsibility for the patient’s care” (Allows two way sharing of information between providers)</td>
<td>CFR Title 45 §164.506 (c) and (2) W&amp;I 5328 (a), 5008, 5013</td>
<td>Recommended not required³</td>
<td>Yes</td>
</tr>
<tr>
<td>Disclosures initiated by the treatment professional “…to a professional person outside the facility who does not have medical or psychological responsibility for the patient’s care.” (Payee, social worker for non-detained minor, school, etc.)</td>
<td>W&amp;I 5328 (a)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Disclosures to facilitate LPS conservatorship proceedings</td>
<td>W&amp;I 5328 (a)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Disclosures for the purpose of “coordinating mental health or medical care” to a DSS Social Worker who is “authorized by the court to have custody or care of a minor (minor is detained or placed)”</td>
<td>W&amp;I 5328.04</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Common Mandatory Disclosures:</td>
<td>W&amp;I 5328 (r), 5328.5 CFR 45 §164.502 (a)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>• Tarasoff Warning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Child or Elder/Dependent Adult Abuse reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Breach reports</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Third Party Disclosures Initiated by a Client or Legally Responsible Person

Staff with one of the specific licensures listed in the table below must approve the disclosure of PHI to a third party when the disclosure is requested by the client. An approving staff with the specified licensure must sign the Authorization to Use or Disclose PHI.
Disclosures to a third party requested and authorized by a parent or other Legally Responsible Person may be approved by any “Qualified Professional”\(^1\). The approving staff will sign the Authorization to Use or Disclose PHI and the Record of Disclosure.

<table>
<thead>
<tr>
<th>Disclosures requested by a Client “When the client...designates persons to whom information or records may be released...” W&amp;I 5328 (b)</th>
<th>Authorization to Use or Disclose PHI needed?</th>
<th>Record of Disclosure needed?(^2)</th>
<th>Approving Staff Credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>MD, licensed Psychologist, LMFT, LPCC, &amp; MSW/LCSW(^7,8)</td>
<td></td>
</tr>
</tbody>
</table>

| Disclosures requested by a Parent/Legally Responsible Person for a minor, ward, dependent and/or conservatee W&I 5328 (d) | Yes | Yes | Qualified Professional\(^1\) (excludes trainees, Reg. Associate without waiver) |

\(^1\)State and Federal law permit disclosure of PHI between “qualified professional persons” in the provision of services without client or Legally Responsible Person authorization. The professional persons must each have “medical or psychological responsibility for the patient's care”. Some third parties will require an Authorization.

\(^2\)Welfare & Institutions Code §5328.6

\(^3\)An authorization is always permitted. Obtaining an authorization may be the best clinical decision, even if not required.

\(^4\)When not the LPS conservator, the Public Guardian is a “professional person not employed by the facility who does not have the medical or psychological responsibility for the patient's care”.

\(^5\)Permissible Disclosures to DSS to coordinate care:

- The disclosure pertains to a minor detained pursuant to Welfare & Institutions Code 300.
- The court issues an order authorizing DSS to obtain and to coordinate mental health services (authorization to obtain general medical care is not sufficient). A copy of the court's order is scanned into the record.
- The information disclosed is, in the MH staff member's clinical opinion, reasonably necessary for the coordination of the minor's care. Nothing in the law requires or compels Mental Health staff to disclose information given in confidence by the minor or the minor's family.

Exclusions:

- Psychotherapy notes
• Any information that is not reasonably necessary for coordination of the minor’s care
• Substance abuse treatment records

6Examples could include disclosures requested by the client to family members or other persons who are not in a professional relationship with the client.

7Note that RNs are omitted and unlicensed MSWs are included; this is not quite the same as LPHA.

8Client directed disclosures to a third party are the only time specifically licensed staff need to sign the Authorization to Use or Disclose PHI. Route the Authorization to Use or Disclose PHI to an appropriate staff member in this circumstance only.

**Single or multiple BH Records of Disclosure:**
A BH Record of Disclosure (BHROD) is the mechanism used to create a record of all third-party disclosure of PHI as required by law. In most circumstances, staff will create a separate BHROD for each disclosure. In some instances, as when identical placement packets are sent to multiple facilities on the same day, a single BHROD will suffice, provided the “To” field states “Multiple facilities” and each facility is listed separately in the text box on the BHROD along with the specific information that was disclosed.

**Routine Record of Disclosure Process:**
The Clinician will:
1. Launch the BH Record of Disclosure (unless already launched by the HIT)
2. Complete the “Disclosed To” section of the BH Record of Disclosure
3. Identify the information to be shared. Print any information to be shared and give it to the Health Information Technician (HIT) or list it in the “Description of Information Disclosed” section of the BH Record of Disclosure. Example: “TAR dated 9/14/14”
4. Complete the “Purpose of Disclosure” section of the BH Record of Disclosure
5. Sign the BH Record of Disclosure as clinician
6. Route the BH Record of Disclosure to the HIT*

The HIT, as custodian of the record, will:
1. Verify that a valid Authorization to Use or Disclose PHI is signed and final approved (when one is needed)
2. Print the PHI identified by the clinician or complete the “Description of Information Disclosed” if the clinician printed the PHI
3. Send or fax the PHI (or assign to an approved AA) and then complete the “Date of Disclosure” field.
4. Sign as Staff Disclosing Information and then Final Approve the BH Record of Disclosure

**Urgent Record of Disclosure Process:**
In certain instances, a client’s treatment need requires more expedited transmission of clinical information. In these instances, the following process will allow rapid response and appropriate logging of disclosures.
The Clinician will:
1. Identify the information to be shared
2. Complete a fax cover sheet, making sure to include:
   a. Date/time of fax
   b. Name and fax number of receiving party
   c. Client MR #
3. Fax the urgent information
4. Staple the fax cover, the PHI disclosed and a fax confirmation sheet and place it in the HIT’s inbox

The HIT, as custodian of the record, will:
1. Launch the BH Record of Disclosure
2. Complete the “Disclosed To” section of the BH Record of Disclosure
3. Complete the “Description of Information Disclosed” section of the BH Record of Disclosure. Example: “TAR dated 9/14/14”
4. Complete the “Purpose of Disclosure” section of the BH Record of Disclosure
5. Route the BH Record of Disclosure to the Clinician

The Clinician will sign as Staff Disclosing Information and then Final Approve the BH Record of Disclosure.

Notes:
1. Minor consent is limited to outpatient services and excludes psychotropic medication, ECT or psychosurgery.

2. 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 and TP.

3. When a minor consents for his or her own services, the record must document:
   - 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)

   - 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; not applicable to Health & Safety Code § 124260 services)
• 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)

4 When a minor consents (or could have consented) for his or her own services, the minor controls access to the record and must sign the Authorization to Use/Disclose PHI prior to third party disclosure (excludes mandated reporting and “must” disclosures).

5 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.

6 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 not 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 Authorization to Use/Disclose PHI.
• 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 her ability to care for herself make her incapable of making intelligent, independent treatment choices. Her parents signed authorization to disclose information to placement 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.”

7 Client signature or the signature of the legal representative is required per Title 9, §1810.440(c)(2) (A).
Appendix J: Travel versus Transportation

**Travel** is a billable component of a reimbursable service when a clinician provides a specialty mental health service at a location other than the office. So, for example, if a clinician travels from SLO Adult Outpatient Clinic to Sierra Vista Emergency Department (ED) to evaluate a client, the Progress Note would include the time it takes to drive to and from the ED. The clinician would also bill for documentation time. Here is how it looks in a time line using round numbers:

- Travel to ED: (:20)
- Crisis Intervention service: (:60)
- Travel back to clinic: (:20)
- Documentation: (:15)

In this example, the total billed would be 1:55 (115 minutes). Travel is reimbursable because it is a component of the service. That is the easy part and is review for everyone.

**Transportation** scenarios can get trickier, because merely transporting a client is neither a reimbursable activity nor a component of a reimbursable activity. Transportation is not included in the Progress Note as Travel Time.

Some of the time spent driving a client can be billable, though. If a clinician actively provides interventions in the car, this is a billable service. Quiet time or casual conversation during the trip is not billable. To determine what is billable, the clinician separates Service Time (time spent providing an intervention) from ‘taxi/ambulance driver’ time. Staff can bill for the former but not for the latter. In the example above, if the clinician brings the client back with them to the PHF and provides ongoing interventions during the drive from the ED, that is a billable continuation of the Crisis Intervention service and not Travel Time. The total time billed would still be 1:55, but it would be allocated differently than the time line above – Service Time would be 1:20 and there would only be travel for the trip to the ED.

Here is another example for what it would look like in a time line if staff transported a client from the ED to Vista Del Mar if some of the drive included billable interventions and some of the time did not:

- Traveled to ED: (Billable, :20)
- Crisis Intervention: (At ED and in car, billable 1:30)
- Transport to VDM & return: (Unbillable, 3:30)
- Documentation: (Billable, :15)

Clinical interventions are billable when provided while driving!
In this example, the clinician would enter 1:30 for Service Time, :20 for Travel Time, and :15 for Documentation Time for a total of 2:05 (125 minutes), even though the whole event took much more time. Staff write in the body of the Progress Note: “Transported client to Vista Del Mar (3:30, not billed)” this makes it clear that we are separating out what is billable from what is not billable.

Rehabilitation Services and Socialization Activities (Day Treatment has different rules) The principles described above are also true when billable services, such as Individual or Group Rehabilitation, are linked together with unbillable activities, such as transportation and socialization. Here is a common example:

A TMHA staff member leaves his office at 9 AM and travels to a client’s home (:10), picks the client up and transports the client to Laguna Park (:15) to meet with peers for a socialization activity. The socialization activity lasts 1:00. The staff member then takes the client back home (:15) and returns to TMHA office (:10) and writes a Progress Note (:10) and is finished at 11 AM.

Question: What is billable in this scenario?

Answer: It depends on what the staff member and the client do in the car!

- If they listen to the radio, chat, make small talk, etc., nothing is billable because no service with interventions occurred. Without a service, this is transportation, not travel.

- If the staff member provides a service (For example: helps the client recognize social anxiety, role plays starting a conversation, practices deep breathing, monitoring/changing self-talk, etc.) while driving, then the time spent engaging in these interventions and the travel to and from the client’s home is billable because the travel is a component of a reimbursable activity. The time the client and peers are engaged in socialization and the time spent driving the client when no service is provided is still not billable. Here is a timeline of this example:

<table>
<thead>
<tr>
<th>Time</th>
<th>Travel</th>
<th>Rehab</th>
<th>Socialization</th>
<th>Rehab</th>
<th>Transportation</th>
<th>Travel</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00</td>
<td>:10</td>
<td>:15</td>
<td>(Unbillable, 1:00)</td>
<td>:05</td>
<td>(Unbillable, :10)</td>
<td>:10</td>
<td>:10</td>
</tr>
</tbody>
</table>

The Progress Note billing ribbon would look like this: Service Time (:20) + Travel Time (:20) +
Documentation (:10) = Total (:50). In the body of the Progress Note, the staff would document the interventions provided and note that the socialization activity and transportation (1:10) were not billed.

**Tips for documenting outings and activities**

1. Provide and clearly document the specific interventions you provide before and after the activity. The purpose of the activity and your interventions must be related to the client’s goals/objectives and focused on reducing impairments that result from the included diagnosis.

   - **Before the outing:**
     Focus your interventions before the activity on helping the client develop the skills needed for the activity to be successful. Identifying obstacles, developing coping strategies, learning or rehearsing skills, and anticipating and preparing for setbacks are common examples of rehab interventions. Clearly document what you did in your Progress Note.

   - **During the outing:**
     Time spent actively providing an intervention is billable, but watching a client socialize is not. Clearly document the interventions you provided and explicitly state what occurred that was not billed in the note (“Client and peers engaged in a walk and talk activity, 3:00, not billed”)

   - **After the outing:**
     Debrief -- talk about what went well, what could improve, etc. Provide feedback and give your client an opportunity to describe the experience for his/her point of view. We all learn from successes and failures. Be sure to have this conversation and document it as a billable intervention.

2. Travel and Documentation are only billable if a service occurred.

3. Transportation is not billable. Explicitly state in the Progress Note that time spent merely transporting a client from A to B was not billed.

4. Make sure your billing reflects the services provided and not additional time. Just because an activity is not billable does not mean it lacks value!
Appendix K: Sample Intervention Planning Tier Narratives

Intervention Planning Tier Narratives

**Note:** DHCS requires a “detailed description of the intervention to be provided”, but an exhaustive list of therapeutic techniques is not necessary. Identify key elements of the service and focus on how the therapy interventions will help the client accomplish the Objective. If you use an EBP or other strategy and maintain fidelity to the model, include it in the narrative. Here is the general formula:

<table>
<thead>
<tr>
<th>Staff will ________</th>
<th>to help (client)</th>
<th>accomplish ____</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Intervention detail, service definition, EBP)</td>
<td>(Objective, Goal or purpose)</td>
<td></td>
</tr>
</tbody>
</table>

### Sample Planning Tier Narratives

<table>
<thead>
<tr>
<th>Case Management</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Refer (client) to ____ for _____ to help (client) utilize community resources to (maintain housing, be successful in school)</td>
<td></td>
</tr>
<tr>
<td>• Coordinate with ___ to help (client) (maintain housing, be successful in school)</td>
<td></td>
</tr>
<tr>
<td>• Monitor (client’s) progress in placement and treatment to help maintain stability (or prevent ...)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collateral Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Help parents develop positive parenting skills to effectively manage (client’s behavior) and improve family relationships</td>
<td></td>
</tr>
<tr>
<td>• Help ___ understand the way trauma affects (client’s) behavior to help her respond more effectively to behavior challenges</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family Therapy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce level of conflict and increase positive expression of feelings to improve family relationships</td>
<td></td>
</tr>
<tr>
<td>• Help family members develop a stronger sense of belonging and ability to handle stresses</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Therapy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Structure and lead group to encourage (goal of group)</td>
<td></td>
</tr>
<tr>
<td>• Model effective communication and maintain safe boundaries for group to (goal of group)</td>
<td></td>
</tr>
<tr>
<td>• Facilitate “Seeking Safety” group (or other Evidenced Based Practice (EBP) or specific group) to (purpose of group)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Individual Therapy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide supportive play therapy to (purpose of therapy)</td>
<td></td>
</tr>
<tr>
<td>• CBT and Solution Focused interventions to help client break negative behavior patterns...</td>
<td></td>
</tr>
<tr>
<td>• TF-CBT (or other EBP or specific modality) to (improve coping</td>
<td></td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Individual Rehab                  | • Teach skills needed to ____ so (client) can (general purpose of rehab)  
• Provide support and skill building activities to (increase a positive behavior or reduce a symptom/impairment)                                                                                                                                                                                                                                                                                |
| Group Rehab                       | • TMHA and MH staff will provide skill building groups to (reduce isolation and improve social skills, develop skills needed to manage $ independently, etc.)                                                                                                                                                                                                                                                                 |
| Intensive Care Coordination        | • Support the family in meeting (client’s) needs to help (client) remain in a family setting  
• Help build a strong team to support (client's/family's) needs so she can remain in her community and school  
• Monitor progress and coordinate services with (client), Social Worker, Treatment Team and (guardian). Child Family Team will meet to evaluate progress and plan ongoing supports needed to help (client) meet her goal of (remaining at home, returning home)  
• Other descriptions may be similar to Case Management                                                                                                                                                                                                                          |
| Intensive Home Based Services     | • Help (client or family member) learn to...  
• Teach self-regulation skills, including...  
• Other descriptions may be similar to rehab                                                                                                                                                                                                                                                                                                      |
| Plan Development                  | • Adjust TP as needed to keep it consistent with (client’s) treatment goals                                                                                                                                                                                                                                                                                                                                                                         |
| Medication Support                | • Med manager and MD/NP will make sure the medication helps reduce (client’s)(cluster of symptoms targeted by the meds or impairment it helps reduce)  
• Med manager and MD/NP will help (client) identify (side effects, benefit, risks) of medication to maintain stability                                                                                                                                                                                                                       |
| Psychological Testing             | • Complex history of prenatal substance exposure, disrupted placements, trauma and family history of mental illness make differential diagnosis and treatment planning difficult. As a result, up to 15 hours of psychological test administration, scoring and report writing will be used to help clarify whether medical necessity criteria are met, whether a medication evaluation would be useful, to identify client’s processing strengths/weaknesses, and to help guide treatment planning. |
| Explain Testing Results           | • Review results with (caregiver) and describe strategies to help (client)(write whatever fits best with the testing question)                                                                                                                                                                                                                                                                               |
Appendix L: Sample Progress Notes

Example of an Assessment Progress Note:
I INFORMED THE CLIENT/RESPONSIBLE PERSON IN LANGUAGE UNDERSTOOD BY THEM OF THE ITEMS MARKED WITH AN 'X' BELOW:

[X] FREEDOM OF CHOICE (Participation is voluntary. Client may request a provider change.)
[X] INFORMED CONSENT (Client has a right to receive information about treatment options or alternatives and to participate in treatment decisions. Client has the right to refuse treatment.)
[X] LIMITS OF CONFIDENTIALITY (Exceptions to confidentiality; mandated reporting)
[X] CONSUMER REQUEST FORM (In lobby, at front desk, or by calling 1-800-838-1381 or (805) 781-4738 to appeal, file a grievance, or request a change in provider.)
[X] FREE INTERPRETATION SERVICES ARE AVAILABLE (Includes interpretation, translation, and aides such as ASL, audio, and large print documents)

I VERIFIED THAT THE CLIENT/RESPONSIBLE PERSON RECEIVED OR KNOWS HOW TO OBTAIN EACH OF THE ITEMS MARKED WITH AN 'X' BELOW:
(Informing materials are available in the lobby or front desk of any clinic, on the BH Website, or by calling 1-800-838-1381)

[X] CONSENT FOR TREATMENT (Give to client or verify that it was given. Contains links to the BH website)
[X] BENEFICIARY HANDBOOK (Tell client how to get it. Give it upon request. Medi-Cal Only; English, Spanish, Large Print, or Audio)
[ ] ADVANCED BENEFICIARY NOTICE (Complete it or verify that it was completed. Medicare Only)
[X] NOTICE OF PRIVACY PRACTICES (Give to client or verify that it was given)
[ ] ADVANCED MEDICAL DIRECTIVE (Adults only. Give or verify that the informing materials were given)
[X] PROVIDER LIST (Tell client how to get it. Give it upon request. Medi-Cal Only)

INTERVENTION:
[X] Completed Assessment: See Assessment and Diagnostic Review for detail
[ ] Completed Assessment Update: See Assessment Update for detail

COMMENTS
(Address relevant Risk Assessment issues, legal responsibility or other issues as needed):
I discussed the above materials with client and aunt to ensure her understanding. Aunt signed Caregiver Authorization Affidavit. Client contracted for safety, provided emergency crisis numbers and agreed to contact clinician if SI/intent returns.
DESCRIBE PLAN/REFERRALS/FOLLOW-UP CARE NEEDED:
Assessment will be presented to Site Authorization Team. See Plan of Action on Assessment.

Example of a Case Management Progress Note:

FOCUS OF SESSION - DESCRIBE RELEVANT ASPECTS OF CLIENT CARE/TREATMENT
(Target symptom and functional impairment; client/family presenting problem(s) today; significant mood, appearance, behavioral or other observations; health risk factors, including SI/HI, if present):
Anxiety and aggressive behaviors impair family and peer relationships. Social Worker called today to discuss potential placement change.

CLINICAL DECISIONS AND INTERVENTIONS
(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):
Therapist talked with social worker regarding plan to move client to adoptive home.
Therapist expressed her concerns with client's current aggressive behavior at home.
Therapist discussed foster parents' concern that client is being moved and recommended strategies for reducing clients anxiety regarding her placement.

CLIENT'S RESPONSE / PROGRESS IN TREATMENT
(Describe how the client/family responded to your intervention(s). Describe client's progress toward his/her objective[s]):
Social worker indicated that the plan is to move the client next week.
Social worker will consider additional supports for client in her new placement.
Social worker indicated that she is continuing to work with foster parents to address their concerns.

DESCRIBE PLAN / REFERRALS / FOLLOW-UP CARE NEEDED:
Therapist will increase frequency of session to 2X per week to assist client with her transition to a new placement.

Example of a Collateral Progress Note:

FOCUS OF SESSION - DESCRIBE RELEVANT ASPECTS OF CLIENT CARE/TREATMENT
(Target symptom and functional impairment; client/family presenting problem(s) today;
significant mood, appearance, behavioral or other observations; health risk factors, including SI/HI, if present):
Met with parents today to work on improving family communication and parenting skills, specifically to finalize work on a positive reinforcement system to shape client's behavior.

CLINICAL DECISIONS AND INTERVENTIONS
(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):
Therapist asked open-ended questions regarding parents' style of communication and beliefs about discipline. Therapist talked with parents about how client's self-esteem could be impacted by parents' communication style. Therapist educated parents on supportive communication styles and role-played examples.

CLIENT’S RESPONSE / PROGRESS IN TREATMENT
(Describe how the client/family responded to your intervention(s). Describe client's progress toward his/her objective[s]):
Parents were hesitant to discuss their beliefs about discipline. Parents were able to recognize the possible impact of their communication style on client's self-esteem. Parents engaged actively in communication role-play.

DESCRIBE PLAN / REFERRALS / FOLLOW-UP CARE NEEDED:
Therapist will meet with client individually to continue to work on developing healthy social and communication skills.

Example of a Crisis Note:

Contact: Elmer Fudd
Relationship to Client: Self
Phone: None

PRESENTING PROBLEM/CLINICIAN’S IMPRESSIONS
(Describe reported concerns with mood, behavior, speech, thoughts or substance use. Describe reported functional impairment in school/job, ADLs, family or social relationships. Address health risk factors, including current or past SI/HI):
Client presented at SLO Outpatient clinic stating he was feeling suicidal. “I just want to go to be with my wife.” Ct was disheveled in appearance and wearing dirty clothing. Ct reported feeling depressed and hopeless over the recent loss of his wife.

DESCRIBE DISPOSITION / PLAN / REFERRALS
(If referred to another agency, specify where):
Staff assessed client for suicide risk (i.e. access to means, history of suicidal gestures or attempts, current plan, and proximity of support system). Client denied current plan for self-harm. Client contracted for safety and agreed to attend scheduled MH assessment appt.

IF MH ASSESSMENT SCHEDULED, WRITE APPOINTMENT INFORMATION BELOW:
Assessment Location: SLO Outpatient
Assessment Date and Time: 8/18/2012
Assessing Therapist's Name: Bugs Bunny

Example of a Medication Support Note:

LPT/LVN Med Support notes have a new template with prompts for important interventions. Review each prompt at each session. If relevant to your session, mark with an X and explain your actions. If a prompt is not relevant, leave the bracket unchecked. What follows shows the prompts in black, explanations of the prompts in red, and a sample note for a depressed client in blue.

FOCUS OF SESSION - DESCRIBE RELEVANT ASPECTS OF CLIENT CARE/TREATMENT (Target symptom and functional impairment; client/family presenting problem(s) today; significant mood, appearance, behavioral or other observations; health risk factors, including SI/HI, if present; indicate any signs which might be related to medication side effects): Why is the client here? Give a snapshot of the client’s presentation.
John is here for monthly medication review. He is severely depressed and unable to manage basic ADLs. He arrives on time, dressed in unkempt clothes and appears lethargic. Has poor eye contact. He denies current SI/HI but when asked what he enjoys in life, says: “I have nothing to look forward to.” He appears flat.

CLINICAL DECISIONS AND INTERVENTIONS (mark all that apply):

[x] Assessed for medication efficacy and side effects (describe):
Reports feeling tired “all the time” and complains of no appetite and reports excess thirst.

[x] Assessed medical issues (describe):
Reports he has an appointment with his PCP next week to check his blood sugar.

[x] Assessed health risk factors, including SI/HI (describe):
His diabetes is not well controlled. Denies SI/HI but expresses hopelessness.

[ ] Educated client regarding medication risks and benefits (describe):

[x] Assessed medication adherence (describe):
John admits that when he oversleeps, he skips his morning dose (2-3 times a week).

[ ] Administered medication (specify medication, dose, route, etc.):
Reviewed record

Review the Record for last and next MD visits, any existing refill orders, accuracy of orders, med adherence, and whether the Medication Log is current and correct. Document each step.

Record was reviewed for availability of refill orders, med adherence, and accuracy of Med Log. John has one more refill available. His morning med adherence is compromised by hypersomnia.

Obtained verbal orders from MD (specify): (See section on Informational Note regarding documentation)

If there are no authorized refills left in the record, you must get a verbal or written order from an MD for new refills. Remember that MD approval (verbal or written) is required on refills before they are faxed to the pharmacy. The documented verbal order must be signed by the prescriber as soon as possible.

Obtained V.O. from Dr. Smith, MD.

Refill called in to pharmacy (unbillable) Specify medication, dosage, quantity, route and pharmacy:

When responding to refill requests check client adherence with MD visits before refilling medications to last them past their next MD appointment. This helps reduce FTS. The Mental Health policy is for clients to be seen at least every 3 months by the MD.

Called CHC pharmacy to refill

1. Prozac, 20 mg po ii q a.m., #60
2. Risperdal, 5 mg po i qhs, #30

Other (specify):

Use this section to document other interventions done that could not be described above. If you talked to the client about housing or non-medication related issues, make a brief statement here and write a separate Progress Note.

Discussed housing options with client. See Case Management note dated 6-3-2011. Not billed with this note.

CLIENT'S RESPONSE (Describe how the client/family responded to your questions regarding efficacy of medication, adherence, side effects, symptoms, medical issues, etc. Describe client's progress toward his/her objective[s]):

Review client's objective for med support with client in session.

John agrees that his adherence “has not been great”, and is open to discussing a different medication with the MD, if appropriate. He says his diet is “OK” but he doesn't know how he can eat better on a limited budget. John says “I am too depressed to look for work”. He has made little progress toward improving ADLs due to severity of depression.

DESCRIBE PLAN / REFERRALS / FOLLOW-UP CARE NEEDED (Next planned contact, next MD appointment, plan for dealing with side effects or medical concerns, etc.):

It is not enough to say “Continue med support.”

Plan: I will consult with MD regarding John’s status.

Referral: See Case Management note.

Follow up: Has an appointment with CHC next week, an appointment with psychiatrist on 7-5-2011, and
one with me on 7-14-2011.

Example of a Plan Development Note:

FOCUS OF SESSION - DESCRIBE RELEVANT ASPECTS OF CLIENT CARE/TREATMENT
(Target symptom and functional impairment; client/family presenting problem(s) today; significant mood, appearance, behavioral or other observations; health risk factors, including SI/HI, if present):
Reviewed progress toward goals and objectives of previous year's Treatment Plan. Created an individualized Treatment Plan with client.

CLINICAL DECISIONS AND INTERVENTIONS
(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):
Therapist reviewed client’s progress toward his treatment goals and objectives.
Therapist explored with client the areas of functioning he would like to improve.
Therapist assisted client in identifying his strengths.
Therapist developed treatment goals and objectives with client.

CLIENT'S RESPONSE / PROGRESS IN TREATMENT
(Describe how the client/family responded to your intervention(s). Describe client’s progress toward his/her objective[s]):
Client was able to acknowledge the progress he has made toward his treatment goals and objectives in the last year.
Client identified 2 areas of functioning that he would like to improve.
Client was able to identify several strengths that he can utilize to meet his goals.
Client actively participated in the development of his treatment goals and objectives.
Client agrees with the current TP.

DESCRIBE PLAN / REFERRALS / FOLLOW-UP CARE NEEDED:
Therapist will submit to SAT for authorization.

Example of an Individual Rehab Note:

FOCUS OF SESSION - DESCRIBE RELEVANT ASPECTS OF CLIENT CARE/TREATMENT
(Target symptom and functional impairment; client/family presenting problem(s) today; significant mood, appearance, behavioral or other observations; health risk factors, including SI/HI, if present):
Client presents for rehab session today as scheduled – he wants to learn to manage his money
so he has enough at the end of each month to buy food.

**CLINICAL DECISIONS AND INTERVENTIONS**
(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):

- Reviewed the material from chapter three of “Managing Mental Illness” with client.
- Helped develop a list of expenses and income
- Helped identify necessary vs. discretionary purchases
- Discussed choices in light of his overall goal.

**CLIENT’S RESPONSE / PROGRESS IN TREATMENT**
(Describe how the client/family responded to your intervention(s). Describe client's progress toward his/her objective[s]):
Client talked how difficult it is for him when he runs out of money and has to go to the food bank or go hungry. He is able to track and participate in discussion and exercises from the workbook. He is realistic about his limited budget and knows he has very little “fun” money. Client indicated that he is continuing to take his medication as prescribed.

**DESCRIBE PLAN / REFERRALS / FOLLOW-UP CARE NEEDED:**
CM will work with client to continue to follow up with client next week to discuss how to maximize food purchases

**Example of a Group Rehab Note:**

**Overview Progress Note:**

SLO Wellness Center Hope House group: “Overcoming barriers to achieve goals”. Focus of today's group was to provide participants with an opportunity to learn and practice skills to assist in maintaining housing.

**GROUP INTERVENTIONS:**
- Taught a problem solving strategy that begins with identifying barriers as a first step.
- Helped clients identify specific barriers they encounter
- Helped each participant begin to break the barrier down into component parts
- Modeled hopefulness, flexibility, help seeking and effective communication
- Helped participants understand the relationship between problem solving and an improved quality of life.

**Individual Progress Note:**
FOCUS OF SESSION - DESCRIBE RELEVANT ASPECTS OF CLIENT CARE/TREATMENT
(Target symptom and functional impairment; client/family presenting problem(s) today; significant mood, appearance, behavioral or other observations; health risk factors, including SI/HI, if present):

Client was clean in appearance, dressed casually. He was in good spirits and cooperative with CM. He was receptive to feedback and interventions. His lack of independent living skills makes it difficult for him to maintain stable housing.

CLINICAL DECISIONS AND INTERVENTIONS
(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):

CM provided client with individual assistance identifying a specific, achievable goal and helped him identify two action steps he could take to begin solving the problem.

CLIENT'S RESPONSE / PROGRESS IN TREATMENT
(Describe how the client/family responded to your intervention(s). Describe client's progress toward his/her objective[s]):

“I’m going to write down my goals and make a list of people who can help me with them.” Client responded very well to support from group leader and a peer, and appeared upbeat and hopeful at the end of the session.

DESCRIBE PLAN / REFERRALS / FOLLOW-UP CARE NEEDED:
Next group meeting scheduled for August 24, 2012. CM will continue to teach client skills for independent living.

Example of an Individual Therapy Note:

FOCUS OF SESSION - DESCRIBE RELEVANT ASPECTS OF CLIENT CARE/TREATMENT
(Target symptom and functional impairment; client/family presenting problem(s) today; significant mood, appearance, behavioral or other observations; health risk factors, including SI/HI, if present):

Client presented as slightly irritable, reporting a recent conflict at home.

CLINICAL DECISIONS AND INTERVENTIONS
(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):
• Therapist provided support and helped client take a step back from the emotional content to look at the relationship process involved.
• Therapist explored client’s irritability and looked for triggers/antecedents.
• Therapist processed client’s feeling regarding family conflict.
• Therapist and client rehearsed “I statements”.
• Therapist assessed for risk factors and ruled out mandatory reporting obligations at this time.

CLIENT’S RESPONSE / PROGRESS IN TREATMENT
(Describe how the client/family responded to your intervention(s). Describe client's progress toward his/her objective[s]):

Client was initially hesitant to talk with therapist.
Client described an argument with mother prior to session.
Client was able to identify her part in the argument and utilize learned coping skills.

DESCRIBE PLAN / REFERRALS / FOLLOW-UP CARE NEEDED:
Therapist will schedule a follow-up appointment with client's mother.
Therapist will continue to assess for risk factors.

Example of a Group Therapy Note:

Overview Progress Note:

Emotional/Behavioral Support Group: Topic is identifying and using appropriate social skills and boundaries.

GROUP INTERVENTIONS:
Therapist welcomed group members and introduced topic. Therapist led group members in a social skills activity -- using “I” statements. Therapist facilitated discussion about the importance of assertive communication.

FOCUS OF SESSION - DESCRIBE RELEVANT ASPECTS OF CLIENT CARE/TREATMENT
(Target symptom and functional impairment; client/family presenting problem(s) today; significant mood, appearance, behavioral or other observations; health risk factors, including SI/HI, if present):

Client’s lack of impulse control and inability to set and maintain appropriate boundaries with peers and school staff impair functioning at school. Client was late today, but came to school in
the afternoon and attended group. Client presented as eager to participate.

CLINICAL DECISIONS AND INTERVENTIONS
(Describe your specific, individualized interventions or decisions aimed at reducing the impairment. If you taught a coping skill or a recovery tool, monitored progress or developed a plan, describe what you did here):

Therapist encouraged client to identify appropriate boundaries in social settings. Therapist reinforced client for providing feedback to other group members, and prompted client to remain on task.

CLIENT'S RESPONSE / PROGRESS IN TREATMENT
(Describe how the client/family responded to your intervention(s). Describe client's progress toward his/her objective[s]):

Client actively participated in group discussion. Client was able to identify times when he used assertive communication to express his needs and another time when he did not. He was able to practice the skill we worked on today and could identify how it might help him be heard. Client volunteered to provide feedback to other group members.

DESCRIBE PLAN / REFERRALS / FOLLOW-UP CARE NEEDED:

Group therapist will consult with client's individual therapist regarding client's progress in group therapy. Next group scheduled for August 25, 2012. Therapist will explore client's difficulty with boundary setting.
Appendix M: Sample Medical Necessity Statements

Severe impairments

- Client's severe social withdrawal/isolation, inability to maintain employment, and multiple arrests due to psychiatric sx(s) can only be treated with specialty mental health services.
- Client's poor social relationships, lack of familial connections, inability to maintain employment and secure stable housing are likely to result in decompensation and a higher level of care without outpatient specialty mental health services.
- Client's severe level of impairments resulted in LPS conservatorship due to his inability to access food, clothing or shelter. Specialty mental health services are required to prevent further marked deterioration.
- Client is not currently capable of independently accessing needed services without the intensive support of a case manager and higher level of care. His needs exceed what can be effectively provided at an outpatient clinic setting. Without additional support, client is likely to decompensate due to his mental illness.

Moderate Impairments

- Client's pattern of isolating self from close family and friends, hx of passive SI w/ no plan) require outpatient specialty mental health services to maintain current gains.
- Client's recent explosive break up of her relationship and eviction from housing require outpatient specialty mental health services to ensure that she does not decompensate and require a higher level of care.
- After numerous unsuccessful trials of oral medication, client is stabilizing on injectable medication that is only available as a specialty mental health service. Without this medication client is highly likely to decompensate and require a higher level of care.
- Frequent family conflicts require coordinated care and home-based interventions to prevent the need for out of home care.

Developmental:

- Client’s angry outbursts with peers and school refusal require specialty mental health services to allow him to develop appropriate social skills. Without SMHS, he is likely to fall further behind peers socially.

EPSDT:

- Even though client's impairments are mild, he needs home-based specialty mental health services to reduce the angry outbursts because caregivers are not likely to access services through other available resources.