COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT
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Practice Guidelines | Annual Progress Summary Service Note

Instructions: When an adult client is primarily being served by a Medication Manager and is not assigned a Clinician, the Medication Manager must complete an Annual Progress Summary via a service note. Utilize the progress note template available in Key Phrases to capture the pertinent clinical information. Address both the bolded topics in black font (this is the template/key phrase text) and helpful tips in blue font. Assign the site HIT as a cosigner to the Annual Progress Summary progress note for processing/flag setting.

Procedure Code:

1) Client Present for Portion of Service: Use Plan Development, Non-Physician, to capture the service time with the client, consulting with the prescriber, and the time spent formulating the Annual Progress Summary. Completing Annual Assessments and Progress Summaries, presenting assessments and treatment recommendations in treatment team meetings are Plan Development services.
2) Client Not Present for Portion of Service: Use Case Management Services for BH Conditions by Physician to capture the time spent consulting with the prescriber and the time spent formulating the Annual Progress Summary. Resolve the Plan Development service that was scheduled with the client to record that the client was absent from the planned service (no show, or cancelled, as appropriate).

Annual Progress Summary Service Note Template:

Information Narrative Box

Current status of presenting problem (describe client's current diagnosis, severity of symptoms, and progress in treatment since last review): Describe any ongoing or resolved symptoms (e.g., mood, behavior, sleep, psychosis, mania, cravings). What is the client's diagnosis(es) and how severe are their symptoms or are they experiencing an improvement/reduction in symptoms.

- Example: “Patient continues to report auditory hallucinations but states they have decreased in frequency. Denies current suicidal ideation.”

Functioning: (ADLs/IADLs) Is the patient maintaining hygiene, attending appointments, managing medications, etc.? Housing/employment/education: Any changes in stability?

- Example: “Patient is living in board and care and attending a day program regularly.”

Medication Adherence: (describe side effects or request for changes) Are they taking medications as prescribed? Noted side effects? Requests for changes.

- Example: “Patient is compliant with Abilify LAI and has not reported side effects.

Current substance use:

Current challenges/barriers to treatment:

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

Are Releases of Information in place?

Referrals needed/offered:

Changes in medical status since last review:

Primary care and specialty care providers:

Outreach to health care providers since last review:

Annual labs completed?

Is client currently pregnant?

Risk factors/safety plan:

Care Plan Narrative Box:

Follow-up plan/next steps:

Consultation with Prescriber on current treatment level of care/need for level of care change: