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

FY 2026-2027

Report suspected inappropriate documentation, coding, or billing practices:

Confidential Compliance Hotline
855-326-9623

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OVERVIEW

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

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

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

✧ Definition of Key Terms ✧

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

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

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

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

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

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

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

Scope of Practice and Role Acronyms:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AND

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

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

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

OR

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

AND/OR

iii. A reasonable probability of not progressing developmentally as appropriate
AND/OR
iv. A need for SMHS, regardless of presence of impairment, that are not included with the benefits that a Medi-Cal managed care plan is required to provide

AND

b. The beneficiary's condition as described in (2) above is due to one of the following:
   i. A diagnosed included mental health disorder
   OR
   ii. A suspected mental health disorder that has not yet been diagnosed
   AND/OR
   iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a LMHP

4. *Definition of Scoring in the High-Risk Range on CANS Trauma Module:
5. Exposure to a specific high impact trauma (e.g., sexual abuse, physical abuse, emotional abuse, neglect, witness to DV, victim/witness to a violent crime, war/terrorism, severe caregiver disruption or abandonment), or
6. Multiple trauma exposures, or
7. Trauma exposure with clinical evidence of impact

The presence of one or more high impact trauma exposure indicators identified on the CANS Trauma Experiences domain, is determined by the LPHA and as applicable, documented as placing the youth at elevated risk.

Natural disasters, accidents, or medical trauma, and community violence without direct victimization would not automatically indicate high risk on their own but may still quality if the LPHA determines the trauma significantly impacts risk or is present with another traumatic experience.

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

✧ Specialty Mental Health Services ✧

SmartCare Procedure Name	Definition/More Information	Disciplines
Assessment Services		
Assessment Contribution non-LPHA	Assessment work/services completed by non-clinical staff. Assessment means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health.	All Providers
Assessment LPHA	Integrated biopsychosocial assessment, including history, mental status, and recommendations.	Licensed, Registered, Waivered Clinician
Review of Hospital Records	Review of records for psychiatric evaluation without direct patient contact.	MD/DO/NP/ Licensed, Registered, Waivered Clinician
Crisis Services		
Psychotherapy for Crisis	Urgent assessment and exploration of an individual in crisis. Includes mental status exam, therapy, mobilization of resources, and implementation of interventions to address the crisis. Client must be present for at least part of the service.	MD/DO/NP/ Licensed, Registered, Waivered Clinician
Crisis Intervention /Mobile Crisis	A service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit.	All Providers
Evaluation & Management Services		
Prescriber Assessment E/M (OP)	Assessment services scheduled with prescribers. Code can be used again with an existing client if there is an extended break in services (6 months), for post-PHF appointments, for second opinions, or if there is significant change in mental status requiring assessment.	MD/DO/NP
Prescriber Progress E/M (OP)	Evaluation and management medication support services provided to established patients. Use for face-to-face or telehealth (audio and video).	MD/DO/NP
Psychosocial Rehabilitation Individual	Prescribers to use this procedure code when providing an E/M service via telephone (audio only).	MD/DO/NP
Prescriber Consult (OP)	Medical decision making, provider sees a patient for an office or other outpatient consultation involving evaluation and management (E/M).	MD/DO/NP
Physician-to-Physician Consult	Consultative physician inter- professional assessment (telephone/internet or electronic).	MD/DO

SmartCare Procedure Name	Definition/More Information	Disciplines
Prescriber Psychotherapy E/M	Psychotherapy services provided as part of an evaluation and management service.	MD/DO/NP
Medication Support Services		
Medication Administration	Administration of oral medication or injection medication with direct observation.	Prescriber, RN, LVN/LPT
Medication Injection	Psychiatric medication intramuscular and subcutaneous injections.	MD/DO/NP/RN
Medication Training and Support	Medication education, training and support, monitoring/discussing/reviewing side effects.	Prescriber, RN, LVN/LPT
Plan Development Services		
Plan Development, non-Physician	Consists of one or more of the following: development, review, or revision of the clinical Client Plan or monitoring a clients progress in symptom management, functioning, and behavioral health services.	All Providers except MD/DO
Targeted Case Management/Intensive Care Coordination		
Targeted Case Management (TCM/ICC)	Services that assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service may include, but are not limited to, communication, coordination, and referral.	All Providers
Care Coordination Outside System of Care	Use for coordination of care activities with providers who are outside the Mental Health system.	All Providers
Care Management Services for BH Conditions by Physician	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • Initial assessment or follow-up monitoring, including the use of applicable validated rating scales • Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes • Facilitating and coordinating treatment such as	MD/DO/PA/NP/RN/ LVN/LPT/Licensed, Registered, Waivered Clinician

SmartCare Procedure Name	Definition/More Information	Disciplines
	psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation • Continuity of care with a designated member of the care team. This procedure/service can be used when: • When a client is being opened to services, during the site authorization review discussion, when the client is being assigned a treatment team and treatment goals are discussed. • During an annual review of the client's progress in treatment, when the annual progress summary is being completed. • For Care planning for patients that are not progressing or have status changes.	
Case Conferences		
Medical Team Conference, Participation by **Physician**. Pt and/or Family Not Present	Medical team conference participation by a physician, with patient and/or family not present.	MD/DO
Team Case Conference with Client/Family Absent	Team conference with interdisciplinary team, participation by a non-physician, with patient and/or family not present.	NP/RN/Licensed, Registered, Waivered Clinician
Team Case Conference with Client/Family Present	Team conference with interdisciplinary team, participation by a non-physician, with patient and/or family present.	NP/RN/Licensed, Registered, Waivered Clinician
MDT/CFT	• MDT = Multidisciplinary Team • CFT = Child & Family Team • Comprehensive multidisciplinary evaluation.	All Providers
Psychosocial Rehabilitation		
Psychosocial Rehabilitation – Individual	Includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.	All Providers
Psychosocial Rehabilitation	Service provided to a group of beneficiaries which	All Providers

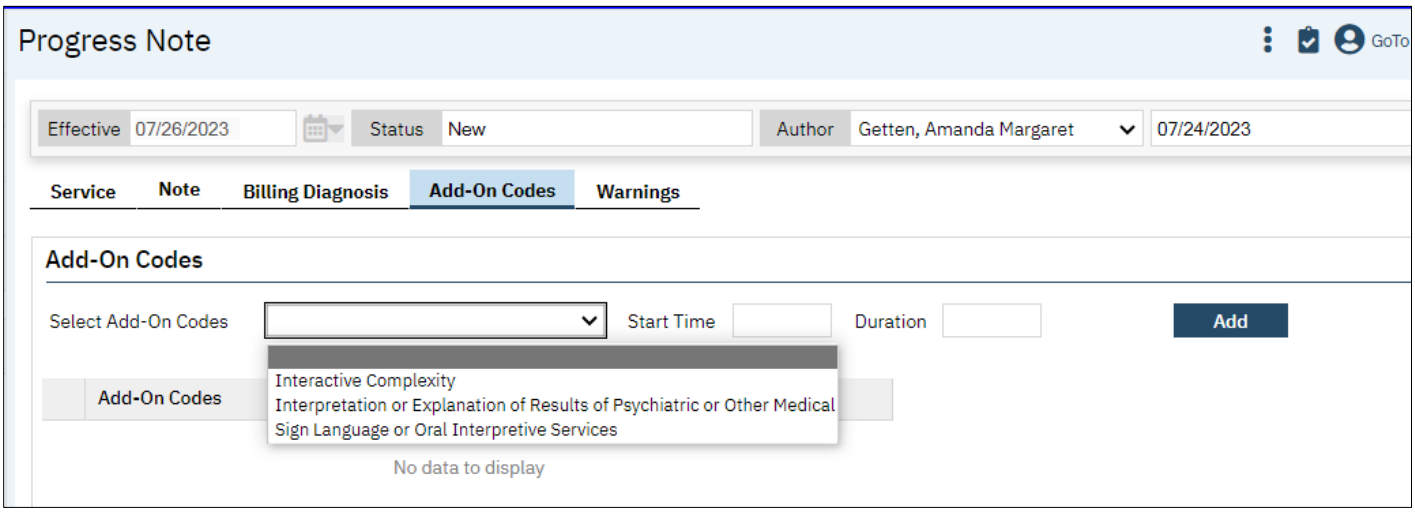
SmartCare Procedure Name	Definition/More Information	Disciplines
Group	includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.	
Therapeutic Behavioral Services		
TBS	• TBS = Therapeutic Behavioral Services • Intensive, individualized, one- to-one behavioral health service.	All Providers
Peer Services		
Self-Help Peer Service	• Self-help/peer services. • Engagement, therapeutic activity.	Certified Peer Specialist
Therapy Services		
Individual Therapy	Focused primarily on symptom reduction and restoration of functioning to improve coping and adaptation and reduce functional impairments. The beneficiary must be present for this service.	MD/DO/NP/Licensed, Registered, Waivered Clinician
Family Therapy – Client Present	Directed at improving the beneficiary's functioning and at which the beneficiary is present.	MD/DO/NP/ Licensed, Registered, Waivered Clinician
Group Therapy	Therapy services that include multiple beneficiaries.	MD/DO/NP/ Licensed, Registered, Waivered Clinician
Multiple Family Group Psychotherapy	Documentation of groups that include multiple families vs. a single family. Therapy may include family therapy directed at improving the beneficiary's functioning and at which the beneficiary is present.	MD/DO/NP/ Licensed, Registered, Waivered Clinician

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

Add-On Codes

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

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



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

COLLATERAL SERVICES

Definition

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

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

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

INTENSIVE CARE COORDINATION (ICC)

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

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

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

ICC service components include the following:

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

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

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

Documenting a CFT

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

INTENSIVE HOME-BASED SERVICES (IHBS)

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

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

Service activities may include, but are not limited to:

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

IHBS Documentation:

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

ASSESSMENT

Definition

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

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

Assessment Documents in SmartCare

The following documents will be completed for intake assessments:

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

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

UMDAP Financial Assessment (Client and clinician signs) Completed Only if there is no funding source, Medicare only, or self- pay	Intake Clinician	Program Supervisor HIT

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

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

Assessment FAQs

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

Assessment Progress Note FAQs:

- The total time for the assessment must be reasonable and supported by the documentation contained in the Progress Notes and in the CalAIM Assessment. Most comprehensive assessments take about 3-4 hours on average to complete. Some cases require less time, while other, exceptionally complex cases may require more time.
- If a therapist sees a client on Monday and finishes the paperwork on Tuesday (when client

is not present), the time spent on paperwork is added to Monday's assessment and billed as one **bundled** service. The write up is an important part of the assessment process, but it is not a separate, stand-alone service.

- Bundle time spent with the client/family, reviewing the client's record, and writing up the clinical assessment documentation for the total amount of face-to-face time included on the service note.
- A progress note template for the Assessment service is available in SmartCare under Key Phrases.

Seven Assessment Domains

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

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

homelessness, juvenile justice, or Child Welfare Services

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

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

- ✓ Safety planning

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

Child and Adolescent Needs and Strengths (CANS)

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

- Assign the site HIT as a cosigner to the CANS Assessment for processing/flag setting.

ASSESSMENT UPDATES

Youth Assessment Updates

A new California CANS and PSC 35 must be completed at regular intervals during a client's treatment episode depending on the age of the client.

Documentation that must be completed for a youth client:

1) CANS (must be completed by a LPHA that has been CANS certified)

Client Age	CANS
0 to 5 ½	Due Annually
5 ½ to 20 (unless client is transferred to an adult clinic)	Due Every Six Months

2) PSC (can be completed by an LPHA, Specialist, or Medication Manager)

Client Age	PSC
3 through 17	Due Every 6 Months

- ✓ Youth BH Clinicians should complete a service note to document this assessment activity

by using the CANS Update Service Note template (found in SmartCare Key Phrases).

- Assign Program Supervisor as cosigner for CANS
- Assign the site HIT as a cosigner to the CANS and the PSC 35 Assessments for processing/flag setting
- Clinician can attach CANS Update Service Note to CANS by associating the documents
- For CANS Update Service Note utilize LPHA Assessment Service Code

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

- A progress note template for the Youth Assessment Update service is available in SmartCare under Key Phrases.

Date of Initial Intake	Every 6 Months After Intake	Date of Closing
Initial CANS/PSC is completed	**Reassessment CANS/PSC is due**	**Discharge CANS/PSC is completed**
Initial CANS/PSC is created and completed at the Initial Intake.	Reassessment CANS/PSC is due every 6 months. *(Reassessment CANS/PCS can be started 2 months before the due date or must be completed 2 months after the due date).	Discharge CANS/PSC is completed when closing a case (Administrative Close– see below).

Urgent CANS/PSC: Done if one is needed between the one-and three-month mark.

- It does not count against the timeline due dates.
- The next due date does not change.

PSC Rules (ages 3-17): Done at Initial Intake and every six months after (Reassessment) then again at closing (Discharge).

- If client is not 3 years old at intake do an initial after 3rd birthday. For cohesion, it is good to time when the next CANS Reassessment is due.
- If client turns 18 years old before a discharge, a "Discharge" PSC does not need to be done. No PSC needed after 18th birthday.

Administrative Close (CANS and/or PSC), only if:

- Discharging a case due to non-response (unable to complete CANS/PSC with client/caregiver).

- Reassessment not completed by two months after due date. Complete an CANS/PSC Administrative Close then do a new Initial to start the timeline over.
- A case is opened/closed at Intake– Clinician does the Initial then HIT does an Administrative Close, when closing the case.

Adult Assessment Updates

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

1. CalAIM Assessment
    - Assign the site HIT as a cosigner to the CalAIM Assessment for processing/flag setting.

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

1. A Plan Development progress note using a progress summary note template Appendix D provides the template for documenting a Progress Summary in a service note.
    - Assign the site HIT as a cosigner to the Annual Treatment Summary progress note for processing/flag setting.

- A progress note template for the Adult Assessment Update service is available in SmartCare under Key Phrases.

TARGETED CASE MANAGEMENT (TCM)

Services that assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service may include, but are not limited to, communication, coordination, and referral.

Example of TCM Interventions:

- *This writer provided TCM services to assist the client in accessing these needed services: LIST*
- *The service activities included: LIST (Communication, Coordination, Referral, Monitoring linkages to needed medical, educational, or social services:*
- *This writer collaborated with the following person(s) to develop the goals of TCM services: LIST (Client, family, SW, PO, teacher, etc.)*
- *Provided linkage, referrals, and/or resource information to client.*
- *Helped client identify needed resources and supports.*
- *Discussed the importance of action (versus passivity) to reduce their depression.*
- *Reminded client of their treatment gains and successes.*
- *Assisted client in formulating answers and completing application.*
- *Helped client develop a plan for managing anxiety while waiting for response to their*

application.
- *Typed and electronically filed their application (15 minutes, not billed)*

Example of TCM Interventions Using TCM Progress Note Template Text:
- *This writer provided TCM services to assist the client in accessing these needed services: Housing services and financial assistance resources.*
- *The service activities included: Communicated client's urgent need for housing and financial assistance resources to the DSS Eligibility Worker assigned to the client.*
- *This writer collaborated with the following person(s) to develop the goals of TCM services: DSS Eligibility Worker*

TCM progress notes are required to include a care plan narrative describing:
- The goals, treatment, service activities, and assistance to address the client's treatment objectives and the medical, social, educational, and other services the client needs.
- The client/legal guardian's active participation in developing these goals
- The course of action to respond to the client's assessed needs
- The client's transition plan when they have achieved their treatment objectives

Example of TCM Care Plan Using TCM Progress Note Template Text:
- *Next appointment is scheduled with this Specialist/Clinician for Case Management on 5/6/2024. The treatment team will continue to support client/provide services to address their general anxiety disorder.*
- *Staff will continue to provide individual therapy, medication management, and case management to support the client with improving functioning in the area of daily living skills and social and communication skills and reducing symptoms of disorganization and social anxiety.*

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

The completion of a referral form/note in SmartCare (referral documentation to a receiving program) is a billable service that may be connected to contact with a client, but this is not required for the service to be billable. The staff member must clearly document that the intervention being provided is a referral that will be of benefit to the client.

Completing paperwork with a client:

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

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

Tips for documenting paperwork completion:

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

Appendix C provides Service Note examples.

- A progress note template for TCM/ICC is available in SmartCare under Key Phrases.

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))

Gravely Disabled is defined by Welfare and Institutions code section 5008 (h)(1)(A) and (h)(2) as a

condition in which a person:

- as a result of a mental disorder, impairment by chronic alcoholism, severe substance used disorder, or a co-occurring mental health disorder and severe substance use disorder,
- is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care.

Crisis Assessment

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

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

1) Service Note: Staff can document the Crisis Intervention service and full crisis assessment in a service note using the Crisis Progress Note Template (see Appendix). For the emergency indicator on the progress note, choose "Yes."
   - A progress note template for the Youth Assessment Update service is available in SmartCare under Key Phrases.

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

Additional documentation tips:

- Use client quotes, to illustrate client's responses. When known, document precipitating events and stresses.
- Clearly state behavioral observations in an objective, nonjudgmental manner.
- During a crisis contact, always ask about document risks to self or others.
- 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
  - ✓ Current drug and alcohol use
  - ✓ Risk of potential substance use relapse
  - ✓ Recent stressors, especially trauma
  - ✓ Hopelessness/lack of future orientation

- ✓ Lack of social support
- ✓ Demographic factors, including age and gender, which may increase or mitigate risk

- Clearly document clinical interventions (including consultations with others) and response
- Consider medical issues. Consult with BH medical staff and/or refer the client to Primary Care or Emergency Department for evaluation/medical clearance if needed
- Clearly document the follow-up plan

Develop and Implement a Safety Plan

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

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

Creating a safety plan can serve as an important crisis intervention tool. Safety plans include coping strategies, social contacts, family contacts, professional contacts, and emergency phone numbers that a client can use when in crisis (anyone who is part of the safety plan should be aware that they are a part of it). Safety plans can be updated as needed when a client develops more coping strategies/supports, and it should be revisited when the client is experiencing thoughts about suicide or there is another crisis/risk situation. A safety plan does not replace a risk assessment – it is a tool that can accompany a comprehensive risk assessment.
For clients with a co-occurring substance use disorder, relapse prevention strategies should be incorporated into the safety plan. These may include: attending a social support group (AA/NA), contacting sponsor, and listing coping skills that help client avoid triggers and triggering situations.

When a safety plan is created with a client in-person, the client shall be provided with a copy of the safety plan. The Counselor/Clinician must take a copy of the safety plan so that it can be scanned into the client's medical record. It is a good idea to make a plan with the client about where they are going to keep their safety plan should they need it.

Crisis intervention services are often provided by telephone and could even be provided by telehealth. When not face-to-face with a client, yet engaging the client in safety planning, the Counselor/Clinician shall ask the client if they would like to receive a copy of the safety plan. The client having a copy of their own safety plan is highly recommended so that they can refer to it if needed. If the client has signed the Consent for Text Communication/Consent for Email Communication (Client) Form, then a copy of the safety plan can be sent to the client via one of these electronic methods. Important: to protect privacy, a Counselor/Clinician should only email from the County email system and any text messages that are sent should only be sent via a County issued cellular phone. Another option is to mail the client a copy of their safety plan, or to give them a copy at the next scheduled face-to-face contact. However, providing a copy via text or email gives the client an opportunity to receive the document quickly.

For more information see the current resources posted on MySLO: https://myslo/DepartmentsNew/Health/Behavioral-Health/BH-Wide-Documentation-Resources/Risk-Assessment-Tarasoff-Documentation-Resources.aspx. A guide to safety planning and safety plan forms can also be found at this location.

MEDICATION SUPPORT SERVICES, LPT/LVN/RN

Definition of Medication Support

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

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

Medication Refill FAQs

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

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

Preapproving the prescription and routing it to the MD:

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

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

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

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

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

- Progress note templates for Medication Support and Medication Administration services are available in SmartCare under Key Phrases.

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

PLAN DEVELOPMENT SERVICES
Definition
"Plan Development" means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress. (Title 9, 1810.232)
The Plan Development service codes are named:

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

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

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

Choosing between Plan Development and TCM

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

TCM: compleing a referral is TCM for all clients.

THERAPY SERVICES

Definition

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

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

Examples of Therapy Interventions

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

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

Scope of Practice Issues

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

- A progress note templates for the first therapy service is available in SmartCare under Key Phrases.

PSYCHOSOCIAL REHABILITATION SERVICES

Definition

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

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

Examples of Psychosocial Rehabilitation Interventions

Most interventions involve 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 them to recall events that preceded their xxx.
- Discussed the red flags with them and inquired about other optional behaviors.

Scope of Practice Issues

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

Attending Med Evaluations

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

Case Consultation/Case Conference:

A "case conference" is a discussion between direct service providers, significant support persons,

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

Service Codes:

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

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

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

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

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

PEER SUPPORT SERVICES

Definition

Peer Support Services are defined as culturally competent services (individual and group) that promote recovery, resiliency, engagement, socialization, self-sufficiency and self-advocacy, development of natural supports, and identification of strengths through structured activities. Individual and group coaching are used to set recovery goals and to identify steps to reach the goals. Peer Support Services can include contact with family members or other collaterals (family members

or other people supporting the beneficiary), if the purpose of the collateral's participating is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's goals. There may be times when, based on clinical judgement, the beneficiary is not present during the service, but remains the focus of the service.

Peer Support Services are provided by certified Peer Support Specialists under the direction of a Behavioral Health Professional who is licensed, waivered, or registered as a qualified provider of SMHS.
Peer Support Services include the following service components:

- Educational Skill Building Groups: beneficiaries and their families learn coping and problem-solving skills to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement: activities and coaching to encourage and support beneficiaries to participate in behavioral health treatment. Engagement can also include supporting beneficiaries in transitioning between level so care and supporting beneficiaries in developing their own recovery goals.
- Therapeutic Activity: structured non-clinical activities that promote wellness, recovery, self-advocacy, relationship enhancement, development of natural supports, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. Therapeutic activities also include advocacy on behalf of the beneficiary, resource navigation, and collaboration with the beneficiary and others (family members or significant support persons).

Service Codes:

Service Type	SmartCare Procedure Name	Description	Disciplines
Group Services	Peer Support	Behavioral Health Prevention Education Service (H0025)	Peer Support Specialist
Individual Services	Peer Support	Self-Help/Peer Services (H0038)	Peer Support Specialist

✧ Progress Notes ✧

GENERAL CONSIDERATIONS

Progress/Service Notes are the heart of the clinical record. A service provided for a client, regardless how powerful or effective, is incomplete until documented. Effective documentation of clinical interventions is a professional, legal, and ethical responsibility of all ~~clinical~~ staff.

Progress notes should use person-centered, strength-based language that acknowledges clients are more than their symptoms or substance use/mental health illness. Words are powerful and can unintentionally lead to biases and further stigmatize individuals. It is not necessary to restate the client's impairment or diagnosis on each progress note.

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

The key functions of Progress Notes are:

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

Who are service notes for:

1. Client: client access to health records will increase with technological advances and the implementation of a patient portal. Access to health care records can empower clients to be more in control of their health care services.
2. Treatment team: service notes serve to keep all providers informed.
3. Yourself: documenting what happened helps clinicians formulate next steps and can serve as a reminder of past services.

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

1. Lengthy narrative.
2. Copy and paste from previous notes.
3. Jargon that makes notes difficult for others to understand.
4. Protected Health Information (PHI) of family/caregivers of the client or other clients.
5. Extraneous information, especially negative comments about other staff members or other clinical disagreements, does not belong in the record.

Progress Notes must document relevant aspects of client care, including clinical decisions made, interventions used, and referrals given to the client. Progress Notes must describe how the intervention reduced a client's impairment, restored functioning, or prevented significant deterioration in an important area of life. In addition, entries in the EHR may be made after phone contact with the client or their parents, conferences with school or probation staff, or other interaction or communication with the client or another person which provides information that is clinically relevant to the client's treatment.

Appropriate Language in Documentation

- Third Party Information: State information gathered from third parties as a report, not a fact (ex. Client's father reports that…").
- Recovery Language: Documentation must be written using strength-based language that reflects the culture of the client and respect for the collaborative process. Relate your interventions to a recovery-oriented paradigm. Remember that a client has broad (and increasing) access to his/her medical record.
- Protected Health Information: Documentation should be related to the health information of the client. Notes should not include PHI about the client's family member(s)/caregivers. Example, in utero substance use would be relevant information for the client's record. However, extensive information about the client's mother's medical information does not belong in the record.
- Abbreviations: Standard abbreviations are acceptable in a note. If you need to abbreviate a word or acronym that is not on the Approved Standard Abbreviation list, spell it out first, and then the abbreviation can be used throughout the rest of the document. Example:
  - California (CA)

⌘ Please click here to view Approved Standard Abbreviation list.

Frequency

Every outpatient service contact must be documented in a Progress Note.

For services that are billed daily, a daily Progress Note is required. This includes:

- SMHS: MH Residential programs, STRTP programs
- DMC-ODS: SUD Residential Treatment programs.

Progress Note Timeliness

Progress Notes must be completed within:

- 3 business days for routine services.
- 24-hours for crisis services.

It is essential for clinical information to be in the chart as quickly as possible to ensure we are best able to meet the needs of clients and coordinate care. Timeliness is determined by the service provider completing the progress note and signing it. If a progress note requires a cosigner, the consigner needs to sign the note as soon as possible so that it can be finalized.

Timeliness is counted starting the day after the service. For example, if a service was provided on a Monday, the first business day for progress note timeliness is counted on Tuesday. Therefore, for the progress note to be considered timely, it must be completed and signed by Thursday that week. Additionally, if there is a holiday during the work week, the holiday is not counted as a business day for progress note timeliness.

Example timeline for a service provided on Friday, 6/27/2025 at 9:00 AM:

- Routine service: must be written and signed by the staff member who provided the service by Wednesday, 7/2/2025.
- Crisis Service: must be written and signed by the staff member who provided the service by Saturday, 6/28/2025 at 9:00 AM.

For Progress Notes submitted outside of 3 business days, it is good practice for the Specialist/Clinician to document why the note is late. For example:

- "This progress note is being submitted four days after the service due to Counselor illness."
- "This progress note was completed five days after the service due to Clinician covering two additional groups due to the unplanned absences of other staff members."

Progress Note Timeliness

SLOBHD has set a timeliness standard for co-signatures. The timeliness standard will be 14 calendar days (10 business days) following the signature date of the service provider.

Accuracy of Billing Information

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

- The service time for an Assessment service was long because the client was frequently perseverating and distracted:
    - "This Clinician minimized distractions as much as possible and prompted the client to return/refocus on the assessment process throughout the session because the

client was distracted and perseverating throughout this service."

- An Individual Therapy service was a long length of time because the client was dysregulated throughout most of the session:
    - "This Clinician focused the majority of session interventions and time on helping and the client regulate his/her/their emotional state as the client presented as highly dysregulated today."
- A Medication Training and Support service was long because the client was reporting medication concerns/side effects:
    - "This LPT gathered the list of client medication concerns and side effects that she is experiencing and communicated these to the MD/NP who was available for consultation."

For group counseling, the Progress Note must accurately record the amount of time each group member participated in the group. Therefore, if one client is excused to leave a group early or arrives late, the time attended must be changed.

Additional Billing Information Tips

- Billable services must include an intervention that addresses a clinical need for the client.
- Clerical tasks are not billable because no intervention occurred that would benefit the client.
- The actual number of minutes a service took should be entered. It is not acceptable to estimate the service time. Refer to the Health Agency's *Fraud, Waste and Abuse Policy* for additional detail.

INDIVIDUAL SERVICE NOTES

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

1) Service Tab: contains important billing and Client & Service Information (CSI) reporting data. Appendix F lists and defines all the Service Indicators.
2) Note Tab: allows the provider to identify the problem(s) addressed during the session, information/interventions, and plan/next steps.
3) Billing Diagnosis Tab:

Service Indicators in a Progress Note: Service Tab

Within the Progress/Service Note, service indicators are selected to indicate where and how a service was delivered, the mode of the service delivery, what service was delivered, and the length of the service.

Status

Case Manager/Clinician/Medication Manager must indicate the status of a service using the

drop-down menu.

- Error
- Scheduled
- Show
- No Show
- Cancelled

Program

The program menu lists the client's current program assignments. Case Manager/Clinician/Medication Manager must indicate which program the service was provided in. If the correct program is not available, contact HIT to help with the client's program enrollment.

Procedure

Case Manager/Clinician/Medication Manager must select the procedure/service name that best describes the service that was provided.

- Please see procedure/service code section for detailed information on procedure codes.

Location

Select the location of the **client** at the time of receiving the service. Commonly used locations are:

- Emergency Room – Hospital
- Home
- Office
- Other Place of Service (use this for a service provided at a partner agency or in the field)
- Prison/Correctional Facility
- School
- Telehealth – Audio & Video
- Telehealth – Audio Only
- Telehealth – Audio & Video – Home (choose this location if the client is participating in a service via telehealth at their home)
- Telehealth – Audio Only – Home (choose this location if the client is participating in a service via telephone at their home)

Note: For appointments with a prescriber via telehealth:

If Provider is Remote, but Client is Present in Office for Telehealth Appointment:

- Location: Office
- Mode of Delivery: Video Conference

If Provider is in Office, but Client is at Home for Telehealth Appointment:

- Location: Telehealth – Audio Video – Home
- Mode of Delivery: Video Conference

Note: The Board of Behavioral Sciences requires that the address of the present location of the client be documented when a service is provided via telehealth. Therefore, a sentence must be added to the progress note narrative such as:
Address of the present location of the client during telehealth service:

Mode of Delivery
Case Manager/Clinician/Medication Manager must indicate the mode of the service using the drop-down menu.

- Face-to-Face
- Telephone (this should match the selected location of the service as either being Telehealth – Audio Only, or Telehealth – Audio Only – Home).
- Video Conference (this should match the selected location of the service as either being Telehealth – Audio & Video, or Telehealth – Audio & Video – Home).
- Written

Cancel Reason
This field becomes active when "Cancel" is selected as the Status of the service. Use the drop-menu:

- Agency/Staff Cancelled
- Consumer Cancelled (Reason Unknown)
- Consumer Cancelled (Childcare/Dependent Care Issues)
- Consumer Cancelled (Illness)
- Consumer Cancelled (Other Reason)
- Consumer Cancelled (Transport Issue)
- Consumer Cancelled (Conflict)

Client was Present

- Checking the "Client was present" box means that the service was delivered directly to the client via face-to-face, telehealth, or telephone.
- This box is automatically checked.
- Uncheck this box if the client was not present for the service. Examples:
    - TCM service took place on the telephone and focused on a discussion about a referral with a partner from another agency.

Collateral Person(s) Present

For collateral person(s) that were present during a service, use this text field to name the role/relationship to the client. More than one collateral person can be entered. Do not enter the name of the collateral(s). Examples:

- Guardian
- Friend/Sponsor

Collateral:	Non-Collateral:
Significant support person(s) in a client's life who are not present because of their employment	Individuals who also support a client's treatment
Examples: • Parent/family member • Friend • Love interest/partner • Coach • Clergy • Neighbor • Service group leader	Examples: • Social Worker • Probation Officer • Teacher • CASA workers

<u>Client Present/Collateral Tips</u>:

- If both the client and collateral people are present, then the "Client was present" field should stay checked AND the "Collateral Person(s) present" field should be filled out.
- If the service was delivered to a collateral person, such as a parent or guardian, and the client was not there, then "Client was present" should be unchecked and the name and relationship of the collateral person should be typed into the "Collateral Person(s) present" field.
- Collateral people are individuals who are important to the client. If you are meeting only with another provider to coordinate care for the client, such as a Therapist and a Peer Support Specialist, both fields should be left blank.

Evidenced Based Practice

Case Manager/Clinician/Medication Manager, if trained in a utilized EBP for the service, must select the EBP from the drop-down menu.

Commonly used EBP's utilized by SLOBHD are:

- Assertive Community Treatment (ACT)
- Forensic ACT (FACT)
- First Episode Psychosis (FEP)

Transportation Service

The field defaults to "No." Enter information if transportation services were provided to the

client by selecting from the drop-down menu.

Start Date
Enter the date of the service. This will automatically fill-in if the service was scheduled from the SmartCare calendar.

Start Time
Enter the time that the service started. This will automatically fill-in if the service was scheduled from the SmartCare calendar.

Travel Time (For Individual Services)
When travel in relation to a service occurs by a Case Manager/Clinician/Medication Manager, total travel time must be recorded in the Progress Note encounter. Travel time is not billed as part of the service claim, but it must be entered so that data about staff time/activities can be studied over time to evaluate the overall costs of providing and being reimbursed for behavioral health services.

When traveling to provide a service, while not required, it is encouraged that the Case Manager/Clinician/Medication Manager also briefly document the travel information in the narrative. Examples:

- Clinician traveled round trip to a Multidisciplinary Team meeting at Social Services.
- Case Manager traveled to the client's residential program for this case management service (one way).

Note: Travel time is different from transportation. Please see later information about transportation.

Documentation Time
The Case Manager/Clinician/Medication Manager must record the total time that was spent completing the Progress Note for individual services in the Progress Note encounter. Documentation time is not billed as part of the service claim, but it must be entered so that data about staff time/activities can be studied over time to evaluate the costs of providing and being reimbursed for behavioral health services. However, if concurrent or collaborative documentation was completed during the service, documentation time must not be added.

Documentation Time for Groups
The Case Manager/Clinician/Medication Manager must record the total time that was spent completing the Group Therapy Progress Note in the Progress Note encounter. This includes time spent recording client attendance.

Service Time
In SmartCare, service time includes all modes of service delivery including face-to-face, telephone (telehealth audio only), video conferencing (telehealth video + audio), and written. This field is where staff should capture the total service time, which for screening and assessment services includes time spent completing the screening and assessment documentation and time spent reviewing the client record (electronic record and intake paperwork).
For group therapy, the Progress Note must accurately record the amount of time each group member participated in the group. Therefore, if one client is excused to leave a group early or arrives late, the time attended must be changed.
Note: Time spent fulfilling mandated reporting activities can be added to the total service time of a service. Time cannot be claimed for completing the written report, however time can be claimed for coordinating/consulting with Child Welfare Services/Adult Protective Services to ensure client safety.

Attending
Do not use this field.

Referring
Do not use this field.
Interpreter Services Needed
Select "yes" if interpreter was needed and enter the interpreter's agency/name.

Language Service Was Provided In
If the service was provided in a language other than English, use the drop-down menu to select the language. Complete this if the staff member providing the service provided the service in another language, or if an interpreter was utilized.

Progress Note Content

Progress Notes must include the following elements which are chosen in the service indicators or are captured in the background of SmartCare:

- Service type (chosen in procedure code)
- Date of service
- Duration of service, including travel and documentation time
- Location of the beneficiary at the time of receiving the service
- Typed or legibly printed name, signature of the service provider and date of signature
- ICD 10 code (on billing diagnosis tab of progress note)

The content of the Progress Note must include the **Interventions** provided by the treating Case Manager/Clinician/Medication Manager and the **Plan**. These are the minimum requirements for the content of the Progress Note. The Case Manager/Clinician/Medication Manger can document more (such as Client Response and Client Progress) as clinically indicated.

1) Narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g. symptom(s), condition, diagnosis and/or risk factors. Provider interventions.
2) Next steps, including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other providers(s) and any update to the problem list as appropriate.

Progress Note Structure: Note Tab

In SmartCare, the progress note prompts the following:

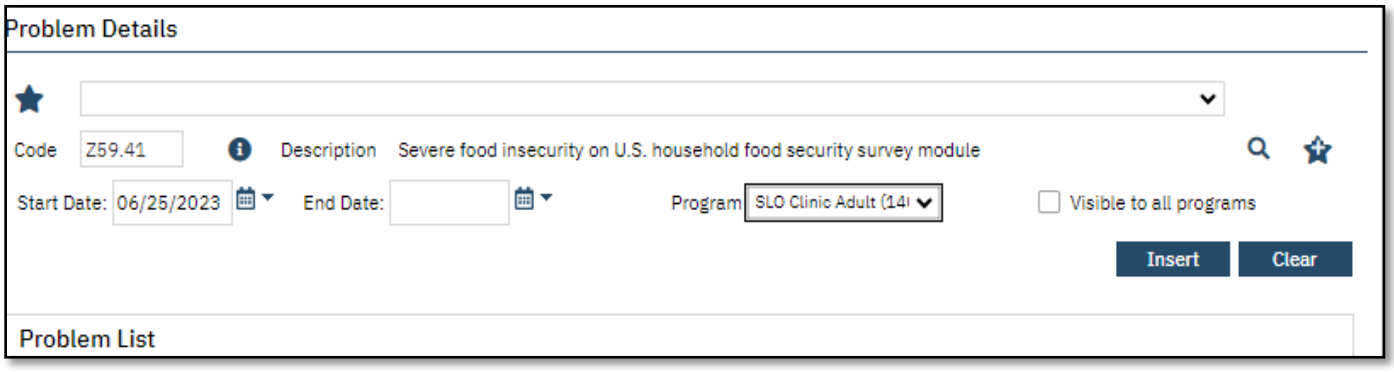
1) PROBLEMS ADDRESSED DURING THIS SERVICE
2) INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors).
3) CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

Problems Addressed During This Service

The problems listed on the Client Problem List Details will be available for selection in this part of the progress note. The problem(s) that were focused on during the session must be selected here.



New problems can be added to the Problem Details section of the note by adding an ICD 10 code in the "Code" field, or search for a problem in the "Description" field. After the appropriate problem is selected, click "Insert" to add the problem to the Problem List.



Interventions

The "Information" section of the note is where the Case Manager/Clinician/Medication Manager must document their interventions. It is not necessary to write an extensive narrative or dialogue during a session or to restate the client's diagnosis or impairment in each note. Interventions are what staff did for the client during the contact to reduce the client's impairments due to their SUD or mental illness, or to prevent deterioration in functioning. Clearly written interventions are the primary proof that the service provided addressed the beneficiary's condition and are the most important part of the note. Bulleted phrases or narrative text are equally acceptable writing styles. Most interventions are directed toward the client, but sometimes directed toward someone other than the client (ex. family).

Intervention Starters:
Acknowledged, Assisted, Brainstormed, Clarified, Created, Defined, Developed, Discussed, Encouraged, Engaged, Explained, Explored, Facilitated, Identified, Inquired, Modeled, Normalized, Practiced, Praised, Prompted, Provided Feedback, Reframed, Reinforced, Reminded, Reviewed, Solicited, Suggested, Supported.

- Click here to view the Interventions Starter list in the Appendix.

Plan

Completing this section of the progress note is required. The Care Plan section of the progress note will carry forward to future progress notes in the same program. It is important that this information is updated/edited to avoid notes with duplicative text.
The "Care Plan" section of the progress note is where the Case Manager/Clinician/Medication Manager must document the plans related to treatment. This can include the plan for the next service or staff plans to follow up on specific treatment issues (ex. referrals, crisis follow up). The Plan could also include plans/action steps identified that the client plans to take. This section can contain plans or goals that are short-term or long-term, and this section can also include overall information about client progress.

- Short-term plans for treatment such as action steps the provider will take, actions that the client has agreed to, next appointments, or plans for coordination with other treatment

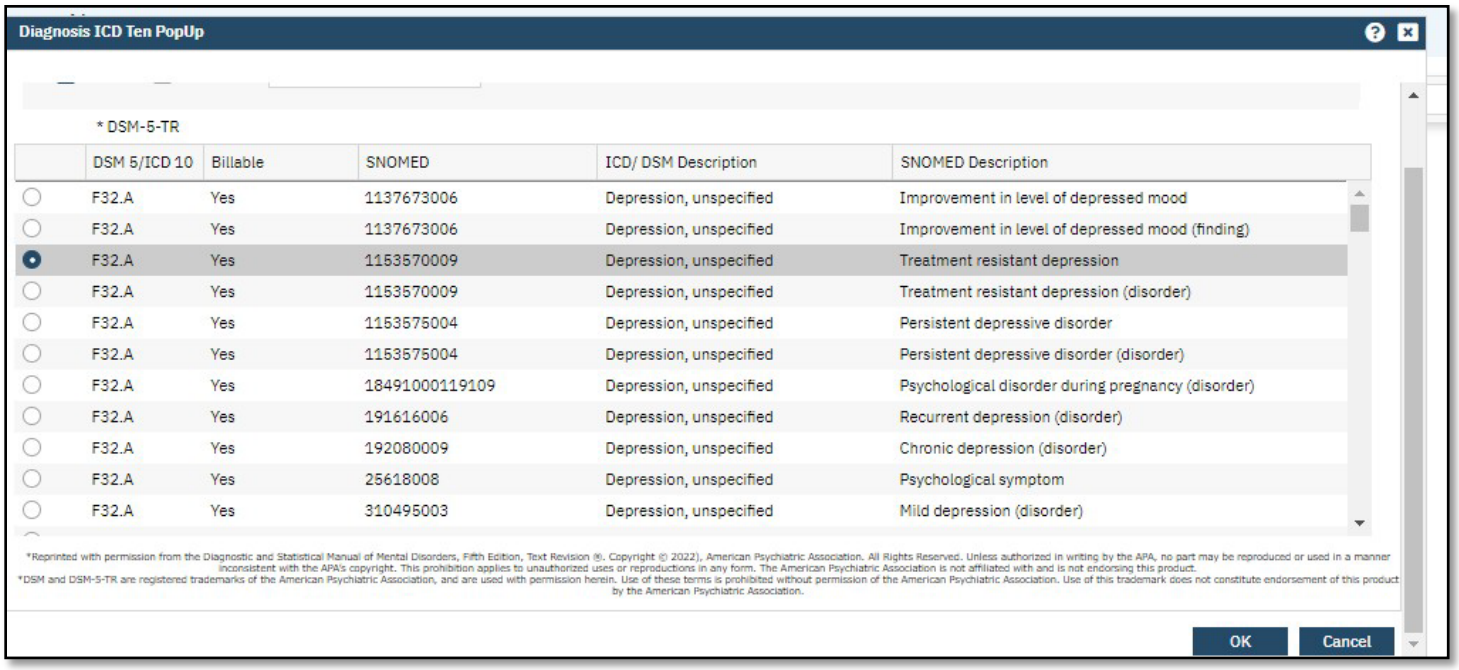
providers. Examples:
    - Next appointment is scheduled with ____ on ____.
    - Client will complete their physical/dental examination on ____.
- Long-term care plans or goals. This information may not change for each service. Examples:
    - Staff will continue to support client/provide services to address ____.
    - Staff will continue to provide individual and group therapy, case management, and medication training and support to assist client with improving functioning in the areas of ____/reducing symptoms of ____.
    - Client wants/plans to seek employment (or return to school).
- Optional content: Client Progress. While interventions and plan/next steps are the required elements of a progress note, it can be clinically important to document the client's progress in treatment. Without occasionally documenting progress/regression, it can be difficult for treatment team members to identify how the client is doing in overall in their services and areas of life functioning. Examples:
    - Client has consistently attended all services for two months. Client has improved in their ability to cope with stressors and has voiced a reduction in anxiety (1-2 days of anxiety experienced per week as opposed to 6-7 days at the start of treatment).
    - Client has recently regressed (last two weeks) in their treatment plan goals by starting to spend time with peers that use. Client reports that they have not relapsed, but that being present with these peers has increased their experience of triggers.
    - Client reports 3 months of consistent medication regimen.
    - Client appears to be working on the stabilization of their living environment as evidenced by moving in with a roommate that does not use drugs or alcohol.
    - Client attended 1 out the last 3 individual/group counseling sessions.

Diagnosis: Billing Diagnosis Tab

There must be a diagnosis(es) on the Billing Diagnosis tab for the note to be completed and to generate a claim. When there is a Diagnosis Document entered for the program under which a service was provided, the Billing Diagnosis tab lists the ICD 10 diagnosis(es). The Billing Diagnosis tab lists the ICD 10 diagnoses from the Diagnosis Document associated with the program for which the service was provided.

If a provider is documenting a service provided prior to establishing an ICD10 diagnosis, the provider may add a one-time billing diagnosis on this tab by clicking the "ICD 10" icon, selecting the appropriate diagnosis, and click "OK."





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

Group Progress Notes

List of Group Participants

For outpatient treatment services, the Group List is maintained in the EHR. Therefore, it is important to make sure that the list of group participants is kept up to date and accurate.

Two Group Facilitators

When there is more than one Case Manager/Clinician/Medication Manager providing a group service, one progress note is sufficient. The progress note must include information about the specific involvement and specific amount of time of each Case Manager/Clinician/Medication Manager in the group activity, including time spent traveling to/from the service and documenting the service. The service must be within the scope of practice of both staff.

Group Size

It is best practice to provide group services to 2-12 participants. For groups with 1 participant, follow the directions in the Group Service Tip section.

"Group Note Summary" Section

Group Interventions:

Write the focus/purpose of the group here. Examples:

- "The goal of the group is to develop conflict resolution skills to help clients improve social relationships."
- "The group focused on teaching budgeting skills to help clients maintain housing."

Next, document specific skill building interventions provided to the entire group in this section. Examples:

- "Clinician used the Seeking Safety curriculum and facilitated a group on the topic of safety."
- "Case Manager taught the group to develop a budget by listing expenses."
- "Welcomed new group member, reviewed group rules, and lead discussion about confidentiality."
- "Modeled effective communication."
- "Rehearsed…"
- "Role played…"
- "Practiced…"
- "Provided materials and reviewed information on…"
- "Facilitated discussion about resources for…"

"Client Note" Section

Problems Addressed During This Session

The problems listed on the Client Problem List Details will be available for selection in this part of the progress note. The problem(s) that were focused on for each client during the session must be selected and individualized here. New problems can be added to the Problem Details section of the note.

Client Response & Plan:

1) Individualize the note by listing any interventions or decisions for each group member.
2) Document a brief description of how the client responded to the service. Each client has unique interactions with other group members and reactions to the topic; document the individual responses as appropriate.
3) Document plan/next steps for the client related to treatment. This can include the plan for the next service or staff plans to follow up on specific treatment issues (ex. referrals, crisis follow-up). The Plan could also include plans/action steps identified that the client plans to take. The Case Manager/Clinician/Medication Manager can choose to individualize the Progress Note and discuss the client's overall progress or regression in treatment, in measurable terms.

Group Service Tips

- Time spent preparing for a group session (i.e. researching and modifying group material) is not time that can be claimed as service time. Clerical functions (photocopying, shopping for supplies, and setting up the room, etc.) are not billable interventions and are not included in the progress note.
- When one client is in attendance for a group service:
  - Leave group service in SmartCare (do not delete).
  - Group Progress Note:
    - "Use "cancel" or "no show" on the progress note service indicators as appropriate for each client scheduled to be in the group. Excuse the sole client that attended the group by choosing "cancel."
      - For the cancel reason, chose "Agency/Staff Cancelled" for the client that attended and is provided an individual service.
    - On the group note summary portion of the group note for the sold client that attended, write "Individual session held with client in lieu of group because client was the only person in attendance."
    - The client note section tab will gray out when "Cancel" or "No Show" are selected for the status field.
    - Because there is not a comment box available on the group progress note when a service is cancelled or a client does not show, information such as the reason why a client was excused must be entered in a "Client Non-Billable Must Document" individual note.
    - The Case Manager/Clinician/Medication manager must document an individual service for the sole client that attended. The treatment staff member can decide what service to provide based on the client's presentation and needs (example: Individual Therapy or Case Management).
- When a group service is cancelled (examples: Clinician ill and group not covered, group not held due to an all-staff training):
  - Leave group service in SmartCare (do not delete).
  - Progress Note:
    - Use "cancel" on the progress note service indicators for each client in the group.
    - "Use "Agency/Staff Cancelled" for the cancelation reason selection.
    - In the progress note narrative it is okay to write "Group cancelled by clinic due to …"
- When a recurring service (groups or individual sessions) falls on a Federal Holiday, the service should be cancelled.
  - Leave service in SmartCare (do not delete).
  - Cancel the service and select the cancel reason "agency/staff cancelled."

- In the Group Summary box or Comments box (for individual services), write "Service cancelled due to holiday."

Bundling Services/Interventions

Services must be bundled for the same procedure code/service type provided on the same date. If not bundled and entered separately, there is risk of Medi-Cal denying one of the services because it might be considered a duplicate service.

To save time, bundle like services/interventions that take place during the same date of service by the same provider into one progress note. Example:

- Do Bundle: On the same date, TCM was provided directly to client for 30 minutes in the morning, and then on behalf of the client for 60 minutes in the afternoon (contacting resources, collaborating with other professionals, linking client to services). Write one progress note for 90 minutes.
- Do Not Bundle: On the same date, Individual Therapy/Counseling provided directly to client for 60 minutes, then TCM service provided to the same client for 30 minutes by the same provider. These are two separate progress notes because the services rendered are different.

Bundling can be documented in the narrative of the progress note in two different ways, depending on staff preference.

1) Bundle by noting time spent on each activity. Example of 115-minute bundled service:

- 11:15-12:05 PM: Contacted three Sober Living providers to inquire about availability for placement (ROI in place). Provided information about one available bed/placement to client's primary Counselor.
- 3:00-3:25 PM: Provided client with Sober Living contact information when client returned this Case Manger's phone call and notified client that a bed/placement was available immediately. Assessed for client needs for transportation to Sober Living and learned that the client had a relative that was prepared to take them this evening. Discussed Sober Living funding plan with client (sober living will be funded 100% for the first 2 months of placement by AB109 program). Contacted Sober Living owner to notify of client's intention to make contact and enter the sober residence today.
- 5:15-5:55 PM: Confirmed by telephone call to Sober Living owner that the client arrived at the residence. Communicated this information to client's team (PO and client's primary Counselor). Completed Sober Living authorization form and sent copy to Sober Living owner via fax.

2) Bundle by timeframe. Example of a 260-minute bundled service:

- Prior the face-to-face assessment, reviewed client's medical record to identify historical clinical information, safety concerns, and history of treatment (35 mins).
- Reviewed consents and informing materials with client/client's parent or guardian to ensure

their understanding. Discussed confidentiality and the limits of confidentiality including mandated reporting and safety (self and others). Completed compressive assessment with client/client's parent or guardian to gather psychosocial information, and information about current concerns and functioning (2.5 hours).
- Formulated the client's strengths and needs in the MH Assessment dated 6/12/2026 which includes access criteria for services and diagnostic information (75 mins).
- Scheduled a follow-up appointment with client/family on 6/15/2026 to discuss treatment recommendations and next steps.

Non-Billable Notes

A "Client Non-Billable Service Note Must Document" is created when a Case Manager/Clinician/Medication Manger wants to document an unscheduled activity during which no service was provided. Here are some examples:

- Leaving a message for a treatment team member.
- Listenting to a voice message that requires documentation.
- Clerical tasks (scheduling, 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.

Targeted Outreach Notes (Non-Billable)

A Targeted Outreach note is created when a Specialist/Clinician wants to document an attempt to reach the client that was not successful. The use of this specific progress note will help outreach attempts stand out in the record from other documentation. Example:

- Outeach call and client does not answer.

Case Management Progress Notes

Case Management individual service Progress Notes are completed with the format of Interventions and Plan. For SMHS, per Federal Requirements, Case Management/Intensive Care Coordination require a treatment plan. To accomplish this in the record, use the TCM/ICC progress note template.

- A progress note template for TCM is available in SmartCare under Key Phrases.

Problems Addressed During this Session

The problems listed on the Client Problem List Details will be available for selection in this part of the progress note. The problems that were focused on during the session must be selected here. New problems can be added to the Problem Details section of the note.

Interventions:
The interventions that the Case Manager/Clinician/Medication Manager performed are listed in this section. These are the staff actions that occurred to assist the client in identifying or achieving needs. Examples are:

- "Assisted Client with phone call to Social Services to make an appointment for food stamps. Rehearsed phone call with Client."
- "Researched current Sober Living Environment openings and provided client with 2 program names and contact information in where there were available beds."
- "Collaborated between Client's Mother (release on file) and Residential Treatment Facility to plan for the client to arrive via family transportation at Residential Treatment tomorrow at 11:00 AM."

Plan:
The plan that the client makes, coordination that will occur, or the plan for future services are listed in this section. Examples are:

- "Client completed her physical examination today and scheduled her dental examination. Client will attend this appointment on xx/xx/xx."
- "Client obtained an appointment at Social Services for xx/xx/xx at 9:00 AM. This Case Manger will provide Client with transportation to the appointment."
- "Client was accepted into a Sober Living Environment and will move in today."

Transportation During Service
For SMHS, transportation is not a billable service/intervention. However, when interventions are provided during transportation, the amount of time spent providing interventions can be claimed. Examples:

- This is not a billable service: "Transported client to Social Services to apply for General Assistance, then transported client to their unemployment appointment."
- This is a billable service: "Transported client to Social Service to apply for General Assistance. During the transportation, staff assisted the client with preparing for the appointment by making a list of the questions they were going to ask. Following this appointment, transported client to their unemployment appointment (time not billed)."

- Please click here to view Progress Note Time Entry Guidance

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



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

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

Progress Note Tips

- Any new problems/treatment issues must be documented in the Progress Note.
- Attempts to contact the client should be entered in a Progress Note when there is a no-show for a service(s). However, the time spent outreaching a client cannot be billed (unless the client is able to be contacted and interventions other than scheduling are provided).
- The service minutes must be documented (do not round time).
- Do not use names of other people in progress notes. Instead, refer to the relationship such as "wife," "spouse," "sponsor," "Probation Officer."
- For Screening and Assessment, the entire information recorded on the corresponding forms is not repeated in the Progress Note. The Progress Note should include summary information about the service, interventions, and decisions made about treatment.
- Do not copy/paste notes.
- Use plain language, no jargon.
- Use person-centered language.

No Shows and Outreach

When a client fails to show for a scheduled service and does not contact their assigned Case Manager/Clinician/Medication Manager, it is best practice that the Case Manager/Clinician/Medication Manager complete an outreach phone call. When resolving a service as "no show," the service provider must go a step further and document an outreach attempt in the Comments box that is available. Examples:

- "Client FTS. This Clinician left client a phone message to follow-up on is absence today."
- "April FTS for the third time this week. This Case Manager left a second phone message to outreach April to encourage her to return to services. CWS Social Worker contacted and message left to coordinate case management."
- "FTS for 4 services. Due to Howard's homelessness and no cell phone, Clinician is not able to call him or send a letter."

When a client stops attending treatment, it is important to conduct outreach and to document

outreach attempts. A minimum of 3 outreach attempts is recommended. A Discharge Summary might state:

- Clinician attempted outreach calls on 3 occasions (see progress notes). Client has not been in contact with Clinician for 30 days and therefore case will be closed. Probation notified xx/xx/xx."

✧ Requests for Services ✧

COMPLETING AN INQUIRY

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

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

A. Central Access Administrative Assistant (AA):
   1. Completes AA portion on Initial, Insurance, and Demographics tab
      - Initial tab – Includes referring agency information, if applicable
      - Insurance tab – Verify Medi-Cal and enter
      - Demographics tab – Enter basic demographic information
   2. Creates a client medical record ID, if applicable
   3. Enrolls client into a SLO MC Authorization program

B. Central Access BH Specialist:
   1. Completes an Adult or Youth Screening Tool (see policy and procedure (P&P) 3.05
   2. Completes disposition portion of Initial tab of Inquiry document
   3. Schedules assessment/screening with the outpatient program
   4. Enrolls client in an outpatient program, if applicable
   5. Assigns client to program staff
   6. Closes SLO MC Authorization program assignment
   7. Completes the CSI Standalone Assessment fields, ***only when a MH assessment is offered and the client declines to schedule***
   8. Completes a TCM service note

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

✧ Special Documentation Scenarios ✧

Urgent Follow-up Services:
If a client has been recently discharged from the PHF, an out of county psychiatric hospital, the crisis stabilization unit (CSU), a hospital, or emergency department (ED), has been released from jail, or recently received a crisis service with the Mental Health Evaluation Team (MHET) these appointments are referred to as "Post" appointments; e.g. Post PHF/hospital/ED/jail/MHET/CSU follow-up appointments. Timely outpatient follow-up after a hospitalization or significant event is critical to assist clients in maintaining the treatment gains achieved during their inpatient stay or crisis intervention service, and to address client needs and decrease risk factors to avoid decompensation and hospital readmissions.

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

Client Hospitalization:
When a client is hospitalized in inpatient psychiatric treatment, outpatient services can continue to be documented, however only discharge planning services can be claimed. The staff member must still document the service they provided and choose Inpatient Psychiatric Facility as the location of the service. TCM/ICC services <u>can</u> be claimed for reimbursement if the reason for the service is to support the client's hospital discharge plan.

Client Incarceration:
When a client is in custody at jail/prison or Juvenile Services Center (JSC), outpatient services can continue to be documented, however cannot be claimed. The staff member must still document the service they provided and choose prison/correctional facility as the location of the service.

Two (or more) Staff Members:
Both staff members can write a progress note and claim for the time that they spent providing interventions that are specific to their role. It is okay if the service time overlaps. Each staff member will choose the service/procedure code that was accurate for the interventions they provided. Examples:

1) A Crisis Intervention service required two staff members. Each staff member could write a Crisis Intervention note that has a short statement about why two staff members were

necessary for the service and also document the specific interventions that they provided, such as "This Specialist and a Clinician were present for this crisis service in order to help maintain safety. While this Specialist stayed with client, the Clinician made phone call to MHET."

2) Two staff members are present for an Individual Therapy session because the client's care is being transferred from one Clinician to another. Each staff member could write a note for this service and choose the procedure code that best fits the interventions they provided (Individual Therapy, Case Management, or Plan Development).

Documentation for a Deceased Client

When the unfortunate situation of a client passing away occurs, the staff member that was notified of the information must notify the site HIT and complete an incident report. The incident report must be reviewed by the Program Supervisor and Division Mnager before it is routed to QSS.

Additionally, when a client passes away, the record is closed and sequestered. Below is guidance on what can/cannot be added to the record.

<u>For a client open to treatment services:</u>

- Services cannot be documented after a client passes away.
- Unresolved service notes after a client's death:
    - Services Notes that have been written but not completed before the client's passing and Service Notes that were completed after the client's passing before staff learns of the client's death: HIT will make these services nonbillable, error out the service, and associate a PDF of the Service Note to the Discharge Summary, so the information will be accessible in the client's record.
- Only the CalMHSA Discharge Summary and a CANS Administrative Close (for youth) can be added to the record.
- If there are outreach calls or other services that were not able to be documented before learning of the client's passing, this information should be added the CalMHSA Discharge Summary.

<u>For a client open to an Intake or an outreach program:</u>

- Services cannot be documented after a client passes away.
- Unresolved service notes after a client's death:
    - Services Notes that have been written but not completed before the client's passing and Service Notes that were completed after the client's passing before staff learns of the client's death: HIT will make these services nonbillable, error out the service, and associate a PDF of the Service Note to the Client Non-Billable Must Document note (see below), so the information will be accessible in the client's record.

- Only a Client Non-Billable Must Document progress note can be added to the record to serve as the Discharge Summary.

✧ Problem List / Diagnostic Review✧

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

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

Problem List Description

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

Problem List Requirements

- A problem or need identified during a service encounter may be addressed by the provider during that service and subsequently added to the Problem List – staff may address client needs before they appear on the client's Problem List.
- Problem Lists are not required to be updated within a specific time period; they are dynamic lists that should be updated as the client's needs change.
- Providers shall add to or end date problems from the Problem List when there is a relevant change to a client's condition/needs.
- Includes:
  - Mental Health diagnoses
  - Substance Use Disorder diagnoses
  - Physical Health conditions
  - Social Determinants of Health Z codes

- Must contain:
  - Name and job title of the provider who identified, added, or removed the problem
  - The date the problem was added or removed
  - Problems that are added to the problem list require that a program is selected. If the Coordinated Care Consent document has been signed, all problems will be viewable (problems added by both SMHS and DMC-ODS programs).

Social Determinants of Health (SDOH) Z Codes

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

Completing Diagnosis Document in SmartCare

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

When a new diagnosis is rendered for a client, a new Diagnosis Document must be added. The criteria for the new diagnosis should be documented in the "comments" section of the Diagnosis Document.

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.

SmartCare brings forward all previously entered diagnoses to the current Diagnosis Document, within the same Clinical Access Data Group (CDAG)/program. As a result, a client could acquire multiple, sometimes conflicting diagnoses if staff add new diagnoses without ending those that are no longer applicable.

Staff must review every active diagnosis for consistency each time a Diagnosis Document is completed. If diagnostic criteria continue to be met, the diagnosis remains active. Enter an end date for every diagnosis that is no longer applicable. Carefully evaluate multiple diagnoses

within a class to determine if contradictory diagnoses exist. Often, rendering a specific diagnosis should result in removing a more general diagnosis of the same class. Some diagnoses have exclusions and cannot occur at the same time as another diagnosis.

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

Diagnostic Review FAQs

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

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

    Staff complete Diagnosis Documents within established scopes of practice.

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

    Notes:

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

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

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

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

    B. Specific ICD10 Diagnoses added to the Diagnosis List
        - Allows staff to record specific ICD10 medical diagnoses previously given to a client by their primary care physician (PCP) or other medical provider. Records from the MD making the medical diagnosis are typically used as a reference.
        - Allows medical staff to render a medical diagnosis.

- **Optional** (Not recommended without detailed information from medical provider unless rendered by medical staff)

Housing Status

There are Behavioral Health Services Act (BHSA) reporting requirements for clients who are unhoused or experiencing housing instability. There are certain housing statuses that must be documented in SmartCare so that they can be included in mandated BHSA reporting. These housing statuses will be captured in SmartCare using:

1) A social determinant of health diagnosis on the Problem List.
2) A Special Population assignment

Documenting housing status in SmartCare will assist the treatment team in identifying clients who would benefit from interventions related to housing. Staff are required to:

- Add the most appropriate diagnosis to the client's Problem List
- Open the appropriate Special Population assignment
- Or do both, if that will best describes the client's housing circumstance

Housing Diagnoses To Add To Problem List:

ICD 10 Code	Description	Definition
Z59.00	Homelessness, unspecified	Client is unhoused, and additional specific information is not known.
Z59.01	Sheltered Homelessness	Living in a shelter such as: motel, emergency/homeless shelter, scattered site housing, temporary or transitional living situation.
Z59.02	Unsheltered Homelessness	Living in a place not meant for human habitation such as: abandoned buildings, cars, parks, sidewalks, street.
Z59.811	Housing Instability, Housed, with Risk of Homelessness	Lacks resources and support networks and currently housed but could lose housing in the next 30 days, with no subsequent residence identified. Examples of this type of housing include: • Residing in a hotel/motel • Living in the home of another due to economic hardship • Sober Living Envrionment/Recovery Residence • Fleeing or attempting to flee domestic violence, sexual assual, or stalking

		• Unaccompanied youth under 25 with no lease and 2+ moves in the last 60 days
Z59.812	Housing Instability, Housed, Homelessness in Past 12 Months	Currently housed but history of homelessness in past 12 months.
Z59.819	Housing Instability, Housing Unspecified	Currently housed but housing is unstable, but specific sub-category is not known.

Special Populations For Capturing Housing Status:

ICD 10 Code	Description
Homeless – Chronic	Unhoused for a combined total of 12 months during the past three years; individual exiting an institution that met other chronic homeless criteria prior to entering institution.
Homeless – Living in an encampment	Unhoused and living with a group of people sleeping outside in the same location with some type of physical structure (e.g. tents) personal belongings, and a sense of community or social support.

✧ Closings/Discharge Summary ✧

When to complete a Discharge Summary:
When a treatment episode ends, staff will document the discharge on the CalMHSA Discharge Summary. Program assignment changes are not discharges (see Transfer process, below). The Discharge Summary is used to summarize treatment, document all closing discussions with client, treatment team, and other treatment providers. If not documented in progress notes, the Discharge Summary can be used to document contact attempts with the client.

CalMHSA Discharge Summary
Use the CalMHSA Discharge Summary to document the discharge summary (as opposed to putting the discharge summary in a progress note). This will make the discharge summary easy to locate in the record.

- If writing a discharge summary is connected to a service, such as a closing therapy session or a closing case management service, the time spent gathering information from the record, conceptualizing and writing the discharge summary can be added to the service time of the termination service.
    - In the progress note, refer the reader to the Discharge Summary dated xx/xx/xxxx.

It is also recommended that the progress note be associated with the Discharge Summary.

- If writing a discharge summary is not connected to a service, such as in cases when contact with a client is lost, a progress note should not be entered. The discharge summary will contain the closing clinical information.
    - Assign MD/Prescriber as a cosigner (applicable if the client is open to medication support services at the time of discharge)
    - Obtain the client's signature on the Discharge Summary
    - Assign Program Supervisor as cosigner
    - Program Supervisor reviews, signs, and then routes the Discharge Summary to the site HIT as a cosigner to process the closing

Use of Key Phrases to Complete the CalMHSA Discharge Summary:

- Key Phrases is what template text is called in SmartCare. Key Phrases have been developed for the CalMHSA Discharge Summary. Use of the Key Phrases template text is required so that all the required elements of a Discharge Summary are documented.
- Proceed with choosing the template text developed for each narrative box on the Discharge Summary. Delete template text that is not needed (directional template text).

See P&P 5.02 Outpatient Discharge Planning for additional direction.
See Appendix P for directions for using Key Phrases.

✧ Transfer of Client Service ✧

Transfers between SMHS programs:

Whenever a client's care transfers from one program to another, take steps to ensure continuity of care and complete a Plan Development service note.

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

- A progress note template for a Transfer Summary is available in SmartCare under Key Phrases.

Information

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

[X] TRANSFER
DESCRIBE: Client has made a plan to move to Atascadero and has requested their services be transferred to the North County Clinic.

[ ] OTHER
DESCRIBE:

DESCRIBE COURSE OF TREATMENT (Include hospitalizations, programs involvement, etc.): Client has received therapy, medication management, and case management services at the SLO Adult Clinic since June 2021. Client has made good progress toward meeting their treatment goals and has stopped receiving therapy services.

CASE REVIEW AT TRANSFER (Include Progress/Goals/Objectives met or not met during treatment and barriers to progress): Client continues to meet access criteria for SMHS due to ongoing symptoms of depression that impacts their ability to work, leave the house, and complete activities of daily living. Client continues to receive medication support and case management services to address their ongoing treatment needs.

SERVICE RECOMMENDATION/ AFTERCARE PLAN: It is recommended that the client continue to receive medication support and case management services to address their ongoing treatment needs.

TRANSFER DISCUSSED WITH (Mark all that apply with an 'X' and describe):
[X] CLIENT
DESCRIBE: This writer has met with the client for a final treatment session and has coordinated this transfer with current and new treatment teams.
[X] PSYCHIATRIST/NURSE PRACTITIONER (Required if client is receiving meds from BH staff)
DESCRIBE (Include steps taken to ensure an adequate med supply until next provider visit): MD was made aware that the client is transferring to the North County Adult Clinic. Medication Manager checked client's medication refill orders, and the client has 2 refills remaining for each medication.
[ ] OTHER SERVERS
DESCRIBE:

Care Plan

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

Client is scheduled to meet with their new medication manager at the North County Adult clinic on (date) at (time). At this appointment, the medication manager will schedule the client for a service with the MD.

After completing the TCM/ICC Service Note:

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

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

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

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

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

Note: The completion of a transfer summary is a billable service that may be connected to contact/coordination with a client or to another provider/agency, but this is not required for the service to be billable. The staff member must clearly document that the intervention being provided is a summarized assessment of the client's status and treatment needs for the purpose of coordinating care with the new provider.

Appendix A – Client Consent

LPS conservatees:

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

Youth Client Signature on Consent for Treatment:

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

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

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

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

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

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

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

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

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

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

Explaining Confidentiality to Minors

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

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

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

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

Appendix B – Documenting a CFT

Child & Family Team Care Plan Template

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

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

Date of CFT:

CFT Participants (Name and role on team):

Follow up on action plans from previous CFT meeting:

Family and client strengths:

Family and client driven plan

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

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

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

Next CFT meeting date/time:

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

SanLuisObispoCntySmartcareQA | 05/14/2024

Progress Note

Client Name:	Fictional 13 SA Client	**Client ID:**	400013	**Status:**	Show
Clinician Name:	Julianne Schmidt	**Service:**	TCM/ICC		
Date Of Service:	05/14/2024	**Start Time:**	10:00 AM	**Face to Face Time:**	75.00 Minutes
Program:	SLO YS Clinic (1602)				
Location:	Telehealth - Audio and Video				
Documentation Time:	15 Minutes				

Problems addressed during this session

- [x] Stress reaction causing mixed disturbance of emotion and conduct (disorder)
- [x] Failure to achieve high school degree and/or equivalent

Information

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

- This clinician facilitated the client's CFT.
- Engaged participants in conversation about the client's services, areas of client and family strengths, identified needs, and action plans.
- Asked questions as appropriate to clarify case specifics.
- Provided psychoeducation and referrals as appropriate.

Care Plan

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

CFT Care Plan:
Specialty Services: (Indicate which service the client will be/is receiving)
x Intensive Care Coordination x Intensive Home-Based Service

Date/Location of CFT: April 15th Telehealth 10am-11:15am

CFT Participants (Name and role on team):
Tyler Gold: Behavioral Health Clinician & CFT Facilitator
Justin Silver: Case Manager FCNI
Sherry Garnet: CWS SW
Jennifer Emerald: FCNI Resource Parent
Jason Topaz: School Psychologist

Follow up on action plans from previous CFT meeting:
• Update were discussed regarding the request for testing at the client's school.
• Updates were discussed regarding client's behaviors at school and at home.
• Updates regarding the client's medical (including immunizations) and dental appointment needs were shared.

Family and client strengths:
• Client and resource parent have bonded through the regular activities of hiking and cooking together.
• Client's behaviors at home have stabilized with a consistent schedule.
• Resource parent is very good at reinforcing positive behaviors and maintaining limits for the behaviors being targeted through mental health services.
• Client has shown a willingness to meet with School Psychologist to participate in testing.

Family and client driven plan:
Identified needs/behaviors/growth opportunities: (include CANS items rated 2/3, describe specific needs the client and family team would like to focus on, describe changes since last CFT)
• Client is still having occasional outbursts/emotional dysregulation and home and at school, although both Resource Parents and School agree that this has improved.
• Resource Foster Parent indicated the client engages in approximately 4 outbursts per week, and this is an improvement from previously 6 times a week.
• Client needs to complete school testing to determine any academic services the client may need to be successful at school (academically and socially).

Action plan and next steps: (include which person(s) is/are responsible for next steps and each part of the action plan)
• Clinician will meet with the client 1x per week for Individual Therapy. Clinician will meet with Resource Foster Parent as needed to provide support, interventions, and psychoeducation.
• FCNI will continue to provide case management services and IHBS services (4-times a week x 3 hours, Monday through Thursday 3:30-6:30).
• Resource Parent will continue to maintain communication with Clinician, Case Manager, and School so that the treatment team can make sure that the client's mental health services needs are being addressed appropriately.
• School Psychologist will complete 3 more sessions with the client (over the next 2-weeks) to finish school testing.

Step Down Plan for end stages of IHBS and TBS (if applicable): Due to the needs of the client (continued stabilization of behaviors at home and school), there is no plan to reduce IHBS service.

Next CFT meeting date/time: May 15th at 10:00am at the home of the Resource Parent & Client.

Staff: Julianne Schmidt, LMFT **Signature Date:** 05/14/2024 2:51PM

Appendix C – Service Note Examples

Assessment Service Note Example:

ClientID: 647437 *Page 1 of 2*

County of San Luis Obispo Behavioral Health

Progress Note

Client Name:	Fictional PIN 03 Client	**Client ID:**	647437	**Status:**	Show
Clinician Name:	Julianne Schmidt	**Service:**	Assessment LPHA		
Date Of Service:	05/01/2025	**Start Time:**	10:00 AM	**Face to Face Time:**	220.00 Minutes
Program:	AT Adult Clinic (2003)				
Location:	Office				
Documentation Time:	10 Minutes				

Problems addressed during this session

- ☐ Opioid abuse, in remission
- ☐ Phase of life problem
- ☑ Bipolar I disorder, Current or most recent episode depressed, Moderate

Information

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

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.)
[X] 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.)
[X] 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 dated (enter date).

COMMENTS (Address relevant Risk Assessment issues, legal responsibility or other issues as needed):
Prior to the face-to-face appointment, this Clinician review the client's behavioral health record to identify historical clinical information, safety concerns, and treatment history (30 mins).
Client actively participated in the assessment, and she appeared comfortable with answering questions and providing information. Client has a history of SI. She last experienced SI two years ago and denies SI since then, including today. Client does not have a history of SA, HI, or SIB. Client lives independently with 2 roommates. She receives SSDI and receives other benefits to help with food and her housing (100 mins).
This Clinician completed the intake assessment. Please see CalAIM Assessment dated 5/1/2025 with full psychosocial information and information about how client meets access criteria for services (90 mins).

Care Plan

ClientID: 647437

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

Follow up phone call scheduled for 5/3/2025 at 3:30pm. Next steps and treatment recommendations will be discussed at this appointment.

Staff: Julianne Schmidt, LMFT **Signature Date:** 05/01/2025 10:01PM

TCM Progress Note Example

Information

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

This Clinician provided TCM services to assist the client in accessing these needed services: housing resources and housing applications.
The TCM service activities included: coordination of care, resource identification, and developed plan for client to complete 2 housing applications this week.
This Clinician collaborated with the following individual(s) to develop the goals of TCM services: Client.

Care Plan

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

Next appointment is scheduled with this Clinician for therapy on 5/13/2024.
This Clinician will continue to support client/provide services to address housing instability, generalized anxiety disorder, and social relationship stability/interpersonal skills.

-OR-

Treatment team staff will continue to provide individual therapy, medication management, and case management to support the client with improving functioning in the area of communication and social relationships/reducing symptoms of general anxiety disorder and social discomfort.

Additional TCM Progress Note Examples

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

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

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

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

  The TCM service activities included: coordination of care.

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

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

- Next appointment is scheduled with Nurse Practitioner for Medication Support on 5/6/2024. Staff will continue to support client/provide services to address the clients mood disorder and instability in relationships and their living environment.
- Staff will continue to provide individual therapy, medication management, and case management to support the client with improving functioning in the area of emotional regulation and reducing symptoms of PTSD.

Crisis Intervention Service Note Example

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

- A progress note template for a Crisis Intervention service is available in SmartCare under Key Phrases.

Information:

PRESENTING PROBLEM: Client is diagnosed with major depressive disorder. The client's wife passed away three months ago, and today he voiced having suicidal ideation. Per client, now that all of his wife's affairs have been attended to and completed, he is now experiencing increased depression.

FOR THE FOLLOWING, IF YES, PLEASE CHECK & DESCRIBE:
[X] Suicidal ideation: Client contacted this therapist by telephone and stated he felt suicidal. "I just want to go to be with my wife." Client reported feeling depressed and hopeless over the recent loss of his wife. Client reported no planning, intent, and reported that he does not have access to any weapons.
[ ] Evidence of Planning:
[ ] Access/Means:
[ ] Intent:
[ ] Homicidal ideation:
[ ] Evidence of Planning:
[ ] Access/Means:
[ ] Intent:
[ ] Self Injurious Behavior
[ ] Access/Means:
[ ] Intent:
[ ] Gravely Disabled:
[ ] Other:

RISK FACTORS, IF YES, PLEASE CHECK & DESCRIBE:
[X] Presence of mental illness: Client has been in SMHS for a period of two years to treat his major depressive disorder. Client is prescribed a SSRI that he has been taking for a period of 2.5 years.
[ ] Substance Use/Abuse: Client stopped drinking alcohol over 10 years ago. He reported that his current grief is not impacting his sobriety and that he has not felt triggered to return to alcohol use.
[ ] History of prior violence/self-injury/trauma:
[X] Recent stressors: Client's wife passed away three months ago. The client is experiencing increased depression and grief. He is having more difficulty sleeping at night and this is causing him to want to sleep more during the day and he is neglecting some of his ADLs (he has been making 1-2 meals/snacks a day instead of 3, and has been showering every 2-3 days).
[ ] Past attempts:
[X] Hopelessness/lack of future orientation: While client reported feeling hopeless today while on the telephone, he also reported plans to go to church this Sunday and that he was looking forward to the support he would receive there. Client was also actively engaged in safety planning.
[ ] Lack of support:
[X] Demographic factors (age, gender, etc.): Client is a 70-year-old male.
[X] Medical Conditions/Medical Concerns: Client has high blood pressure and takes medication for it. This has been a condition for the client for 10 years.

BEHAVIORAL OBSERVATIONS (DESCRIBE ANYTHING SIGNIFICANT RE: APPEARANCE, BEHAVIOR, SPEECH, MOOD, ETC.):
Client was tearful while on the telephone with this Therapist, but was also able to communicate clearly. Client reported that

PROTECTIVE FACTORS: Client is connected to a church that he attends 2-3 times a week, and he has a 19-year-old grandchild that is currently living with him. Client said, "I am not going to hurt myself or kill myself. I called you though because I have not had suicidal thoughts in over 2-years, and the hopelessness and not sleeping is really getting to me." The client's 19-year-old grandchild was present while the client phone this Therapist, therefore there is a family member that is aware of the client's suicidal thoughts and safety plan.

Care Plan:

SAFETY PLANNING: Client and therapist completed a safety plan. Therapist emailed a copy of the safety plan to the client, and client made a verbal plan to tape his safety plan to the inside of one of kitchen cabinets for easy reference. The safety plan includes crisis contact phone numbers, professional and personal contact information for those that he can contact when he needs to talk/support. Coping skills were also listed on the safety plan.

DISPOSITION AND NEXT STEPS: Client agreed to attend an individual therapy session tomorrow at 10:00am. A plan was also made for this therapist and client to talk by phone at 4:30pm today to assess his condition. Therapist scheduled a medication support visit for the client to see the psychiatrist in 2-days to discuss any potential changes to his medications to help with his current depression. Therapist also recommended that the client schedule to see his PCP to have his annual physical examination completed and to check his blood pressure.

IF CLIENT IS A DANGER TO OTHERS (TARASOFF), DID YOU:
[ ] Phone call to intended victim(s)
[ ] Send Tarasoff notification letter
[ ] Phone call to law enforcement
[ ] Send Tarasoff worksheet to law enforcement

Plan Development Service Note Example:

Information

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

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

Care Plan

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

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

Individual Therapy Service Note Example:

Information

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

This writer processed client's feeling regarding family conflict. This writer and client rehearsed "I statements" to assist client in expressing their needs and feelings without others interpreting them as blaming or accusing. This writer assessed for risk factors and ruled out mandatory reporting obligations at this time. This writer scheduled a Family Therapy session for next week with client and their family. This writer will continue to assess for risk factors.

Care Plan

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

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

Psychosocial Rebab Service Note Example:

Information

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

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

Care Plan

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

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

Appendix D – Service Note Templates

Adult Assessment Progress Note Template:

I INFORMED THE CLIENT/RESPONSIBLE PERSON IN LANGUAGE UNDERSTOOD BY THEM OF THE ITEMS MARKED WITH AN 'X' BELOW:
[ ] FREEDOM OF CHOICE (Participation is voluntary. Client may request a provider change.)
[ ] 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.)
[ ] LIMITS OF CONFIDENTIALITY (Exceptions to confidentiality; mandated reporting)
[ ] 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.)
[ ] 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)
[ ] CONSENT FOR TREATMENT (Give to client or verify that it was given. Contains links to the BH website)
[ ] 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)
[ ] 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)
[ ] PROVIDER LIST (Tell client how to get it. Give it upon request. Medi-Cal Only)

INTERVENTION:
[ ] Completed Assessment: See Assessment and Diagnostic Review for detail
[ ] Completed Assessment Update: See Assessment dated
[ ] Assessing Clinician reviewed the record and other available documentation to identify historical clinical information, safety concerns, and treatment history.

COMMENTS (Address relevant Risk Assessment issues, legal responsibility or other issues as needed):

Follow up phone call scheduled for (date) at (time).

***** next section is for telehealth only appts*****
telehealth: [ ] yes [ ] no
Client verbally consented to being treated by an associate therapist. [ ]yes [ ] no
Client verbally consented to have Medi-Cal billed for insurance and verbally agreed to cost agreement. [ ] yes [ ] no
Client would like all verbally approved documents mailed to residence
Type of insurance:
# of dependents:
Income:
Phone number:

Youth Assessment Progress Note Template:

I INFORMED THE CLIENT/RESPONSIBLE PERSON IN LANGUAGE UNDERSTOOD BY THEM OF THE ITEMS MARKED WITH AN 'X' BELOW:
[ ] FREEDOM OF CHOICE (Participation is voluntary. Client may request a provider change.)
[ ] 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.)
[ ] LIMITS OF CONFIDENTIALITY (Exceptions to confidentiality; mandated reporting)
[ ] 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.)
[ ] 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)
[ ] CONSENT FOR TREATMENT (Give to client or verify that it was given. Contains links to the BH website)
[ ] 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)
[ ] NOTICE OF PRIVACY PRACTICES (Give to client or verify that it was given)
[ ] PROVIDER LIST (Tell client how to get it. Give it upon request. Medi-Cal Only)

INTERVENTION:
[ ] Completed Assessment: See Assessment and Diagnostic Review for detail. Also see Mental Status Examination, CANS, Pediatric Checklist, and CSI Standalone Collection.
[ ] Completed Assessment Update: See Assessment dated
[ ] Assessing Clinician reviewed the record and other available documentation to identify historical clinical information, safety concerns, and treatment history.

COMMENTS (Address relevant Risk Assessment issues, legal responsibility or other issues as needed):

Follow up phone call scheduled for (date) at (time).

***** next section is for telehealth only appts*****
telehealth: [ ] yes [ ] no
Client verbally consented to being treated by an associate therapist. [ ]yes [ ] no
Client verbally consented to have Medi-Cal billed for insurance and verbally agreed to cost agreement. [ ] yes [ ] no
Client would like all verbally approved documents mailed to residence
Type of insurance:
# of dependents:
Income:
Phone number:

TCM/ICC Information Narrative

This writer provided case management services to assist the client in accessing the following needed service(s): LIST
The service activities included: LIST (Communication, Coordination, Referral, Monitoring linkages to needed

medical, educational, or social services):

This writer collaborated with the following person(s) to develop the goal(s) of this case management service: LIST (Client, family, SW, PO, teacher, etc.)

TCM/ICC Care Plan Narrative

Next appointment is scheduled with _____ on _____. Staff will continue to support client/provide services to address _____.
Staff will continue to provide individual therapy, medication management, and case management to support the client with improving functioning in the areas of _____ / reducing symptoms of _____.
Identified course of action: LIST
The client's transition plan when they have achieved their treatment objectives: LIST

Youth Assessment Update Service Note Template

Information Narrative:

This clinician met with client and ____ [i.e. parent/guardian] to complete an assessment of the client's strengths and needs. Please see CANS and PSC assessments dated ____ [enter date here].

Include any relevant information in the following areas (use N/A when appropriate):

- 300 dependent/Katie A subclass:
- Changes in living situation/caregivers:
- Medication changes:
- Other significant changes:

Care Plan Narrative:

Client, who has been receiving services for [length of time OR since last intake date of ___] and continues to meet access criteria and this clinician recommends the following treatment plan for the next six months: [weekly therapy, case management services as needed, medication support services as directed, etc.] in order to [statement about needs and functioning: reduce symptoms of depression and anxiety, to increase distress tolerance to support, to improve functioning in relationships/school performance, etc].

OR

The client has met their treatment goals and is ready to transition to a lower level of care. This clinician will work with the parent/guardian to connect the client with a CenCal provider.

Adult Assessment Update

INTERVENTION:

[ ] 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):

Annual Progress Summary Service Note Template

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

Functioning: (ADLs/IADLs)

Medication Adherence: (describe side effects or request for changes)

Current substance use:

Current challenges/barriers to treatment:

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

Are Releases of Information in place?

Referrals needed/offered:

Changes in medical status since last review:

Primary care and specialty care providers:

Outreach to health care providers since last review:

Annual labs completed?

Is client currently pregnant?

Risk factors/safety plan:

Follow-up plan/next steps:

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

Medication Support Service Note Template for Medication Manager

Reason for today's visit:

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

Ordering MN/DO/NP:

Name of pharmacy (for refill verification):

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

List any new problems identified:

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

Next Steps: Referrals provided/needed, Follow up appointment

Crisis Intervention Service Note Template

PRESENTING PROBLEM:

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

[ ] Suicidal ideation:
    [ ] Evidence of Planning:
    [ ] Access/Means:
[ ] Homicidal ideation:
    [ ] Evidence of Planning:
    [ ] Access/Means:
[ ] Self Injurious Behavior
    [ ] Access/Means:
[ ] Gravely Disabled:
[ ] Other:

RISK FACTORS, IF YES, PLEASE CHECK & DESCRIBE:

[ ] Presence of mental illness:
[ ] Substance Use/Abuse:
[ ] History of prior violence/self-injury/trauma:
[ ] Recent stressors:

[ ] Past attempts:

[ ] Hopelessness/lack of future orientation:

[ ] Lack of support:

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

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

PROTECTIVE FACTORS:

CURRENT OVERALL LEVEL OF RISK:
[ ] Low (e.g., Develop/review Safety Plan and provide after hours emergency/crisis numbers)
[ ] Moderate (e.g., Develop/review Safety Plan and provide after-hours emergency/crisis numbers. Consider further need for immediate crisis assessment and intervention)
[ ] High (e.g., Engage in additional immediate crisis assessment and intervention and determine appropriate level of care)

SAFETY PLANNING:

DISPOSITION AND NEXT STEPS:

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

[ ] Phone call to intended victim(s)

[ ] Send Tarasoff notification letter

[ ] Phone call to law enforcement

[ ] Send Tarasoff worksheet to law enforcement

Appendix E – PN Intervention Starters

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

Appendix F – Standard Abbreviations

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

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

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

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

Appendix G – Progress Note Service Indicators

Service indicators on Progress Notes

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

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

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

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

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

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

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

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

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

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

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

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

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

Attending – Do not use this field

Referring – Do not use this field

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

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

Appendix H - PN Time Entry Guidance

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

Appendix I – Urgent Service Follow-Up

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

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

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

Documentation Workflow

Did client keep first appointment?

No →

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

Yes ↓

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

Did client keep scheduled assessment?

No →

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

↓

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

Yes ↓

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

←

Appendix J – Social Determinants of Health

Description	ICD 10 Code
Academic or Educational Problem	Z55.9
Unemployment Unspecified	Z56.0
Other Problem Related to Employment	Z56.89
Homelessness	Z59.00
Inadequate Housing	Z59.1
Discord with Neighbor, Lodger, or Landlord	Z59.2
Problem Related to Living in a Residential Institution	Z59.3
Lack of Adequate Food or Safe Drinking Water	Z59.41
Extreme Poverty	Z59.5
Low Income	Z59.6
Insufficient Social Insurance or Welfare Support	Z59.7
Unspecified Housing or Economic Problem	Z59.9
Phase of Life Problem	Z60.0
Problem Related to Living Alone	Z60.2
Acculturation Difficulty	Z60.3
Social Exclusion or Rejection	Z60.4
Target of (Perceived) Adverse Discrimination or Persecution	Z60.5
Unspecified Problem Related to Social Environment	Z60.9
Child in Welfare Custody	Z62.21
Personal History (past history) of Physical Abuse in Childhood	Z62.81
Parent-Child Relational Problem	Z62.82
Personal History (past history) of Sexual Abuse in Childhood	Z62.81
Personal History (past history) of Psychological Abuse in Childhood	Z62.811
Personal History (past history) of Neglect in Childhood	Z62.812
Child Affected by Parental Relationship Distress	Z62.898
Relationship Distress with Spouse or Intimate Partner	Z63.0
Uncomplicated Bereavement	Z63.4
Disruption of Family by Separation or Divorce	Z63.5
High Expressed Emotional Level Within Family	Z63.8
Problems Related to Unwanted Pregnancy	Z64.0
Problems Related to Multiparity	Z64.1
Discord with Social Service Provider, Including Probation Officer, Case Manager, or Social Services Worker	Z64.4
Conviction in Civil or Criminal Proceedings without Imprisonment	Z65.0
Imprisonment or Other Incarceration	Z65.1

Appendix K – Medication Manager Service Note Examples

Mental Health Medication Example Note #1

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

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

Ordering MN/DO/NP: Dr. Puri

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

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

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

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

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

Mental Health Medication Example Note #2

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

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

Ordering MN/DO/NP: Dr. Lampe

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

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

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

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

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

Mental Health Injection Medication Example Note #3

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

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

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

Ordering MN/DO/NP: Dr. Penepacker

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

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

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

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

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

Case Management Service Note Template & Examples for Medication Managers

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

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

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

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

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

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

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

  The TCM service activities included: coordination of care.

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

services: Pharmacy, Prescriber, Client.

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

  The TCM service activities included: coordination of care.

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

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

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

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

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

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

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

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

Changes in medical status since last review: No changes.

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

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

Annual labs completed? Yes. Glucose was moderately elevated.

Is client currently pregnant? NA

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

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

Appendix L – Transition of Care

Transition of Care Tool for Medi-Cal Mental Health Services

REFERRING PLAN INFORMATION

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

Submitting Plan: San Luis Obispo

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

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

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

BENEFICIARY INFORMATION

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

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

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

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

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

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

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

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

Behavioral Health Diagnosis or Diagnoses, if known:

Recent Diagnosis Document Attached to End of Form.

Supporting Clinical Documents Included:

No Recent CalAIM Assessment.

No Recent CANS Assessment.

Cultural and Linguistic Requests:

Primary Language: Spanish.

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

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

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

[X] Additional Pages Attached

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

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

☐ Additional Pages Attached

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

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

☐ Additional Pages Attached

Brief Medical History:

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

☐ Additional Pages Attached

Current Medications/Dosage:

See attached document.

☒ Medication List Attached

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

See attached Tx Team document.

SERVICES REQUESTED:

☒ **Transition Care to:** CenCal

☐ **Adding Service(s) from:**

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

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

TRANSITION OF CARE OR SERVICE REFERRAL DESTINATION

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

Managed Care Plan Contact Information

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

☐ **County Mental Health Plan:**

County Mental Health Plan Contact Information

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

Behavioral Health Diagnosis or Diagnoses, if known:

CalMHSA - San Luis Obispo County

Diagnosis Document

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

Diagnosis

Alcohol use disorder, Severe

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

Paranoid schizophrenia

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

Additional Information

Screening Tools Used

Other General Medical Conditions

Psychosocial, Environmental, and Other Factors

Comments

Level of Functioning Score

GAF Score

WHODAS Score

CAFAS Score

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

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Current Symptoms and Behaviors:

Current Presenting Symptoms/Behaviors:

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

Current Medications/Dosage:

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

Diagnosis

ICD 10 Code: F41.1 - Generalized anxiety disorder

Medication List

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

Primary Care Provider/Current Care Team:

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

Current Treatment Team:

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

Current Treatment Team:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Current Treatment Team:

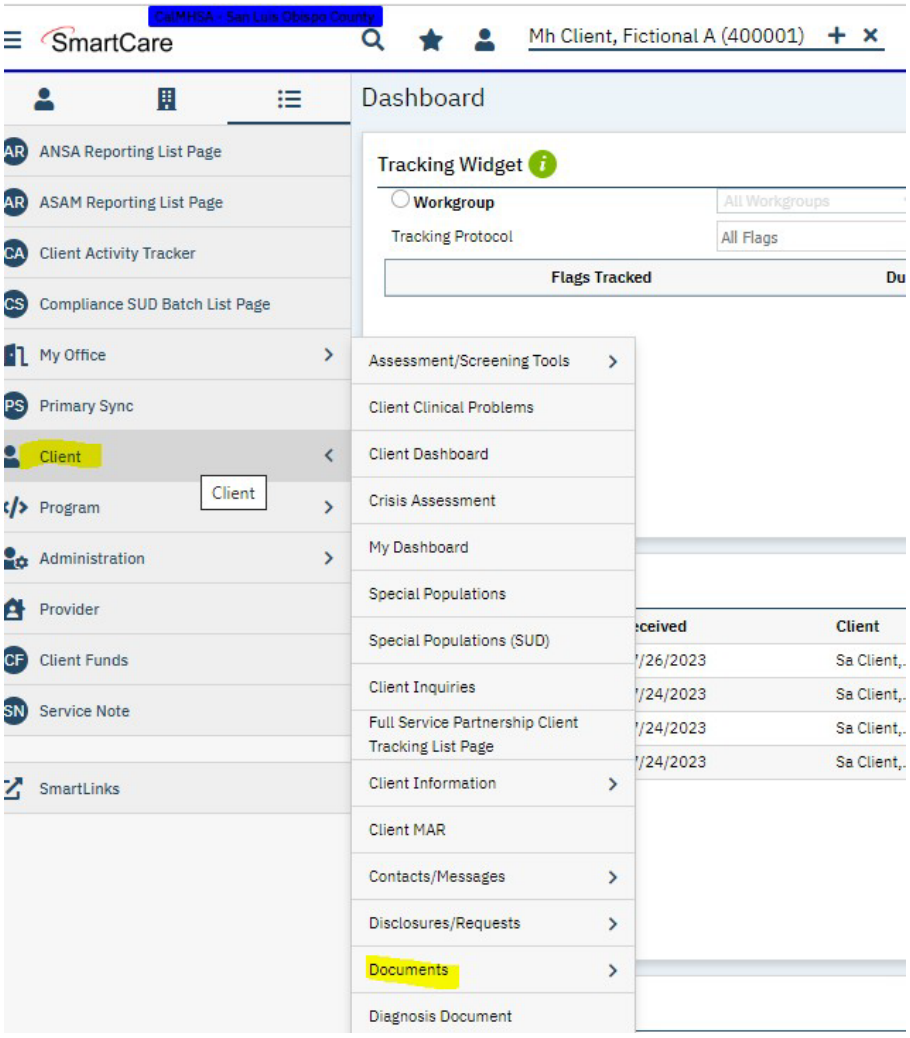
Treatment Team Staff Name	Role	Program	Staff Email	Staff Phone
Martinez, Jennifer Ramirez		NCA MHSA Case Mgr Youth (2089)	jmartinezramirez@co.slo.ca.us	

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

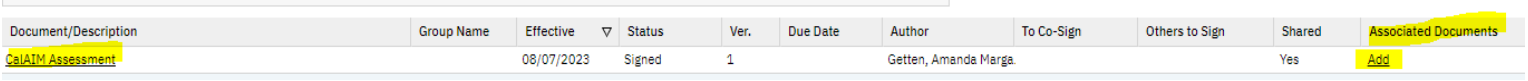
Appendix M – How to Associate a Progress Note with a Document

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

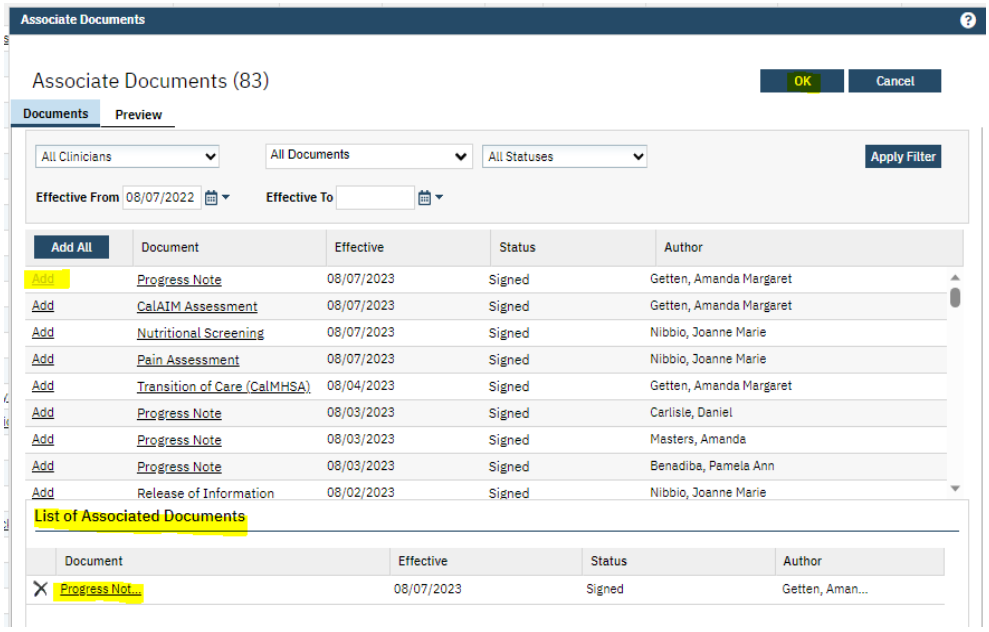
1. Open Documents List page



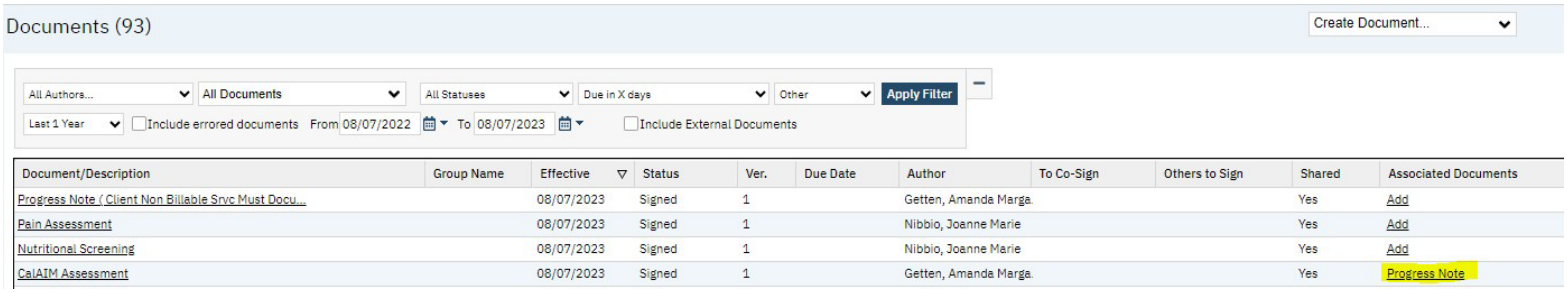
2. Find the document/progress note on the document list page and click **Add** under Associated Documents



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



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



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

Post Appointments Open Clients Workflow

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

Post Appointments for Clients Not Currently Open to Services Workflow

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

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

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

Information/Interventions:

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

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

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

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

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

- Completed a brief screening of substance use by asking the client about current use and if they wanted/need help with substance use.
- Helped client identify what lead up to their PHF/CSU intervention and if anything could have prevented their crisis.
- Engaged the client in a review of their safety plan to monitor that it was up to date. Part of the safety plan review included a discussion about how coping skills, social supports, and community resources may help prevent a crisis in the future.
- Engaged the client in a review of their safety plan and completed a safety plan update to add one additional emergency contact number and one additional social support phone number.
- Discussed with the client where they will store their safety plan so that they know where to access it during a crisis.
- Assisted the client with programming the Hotline phone number into their phone to promote ease of use of this resource should there be a crisis.
- Inquired with the client about additional support and resources that they need and supplied the following: DSS for food/cash aid, Veterans services.
- Obtained Releases of Information in order contact the client's other support persons in the event of a crisis.
- Reviewed the client's plans for ongoing Mental Health services (assessment, medication evaluation, case management, and options for therapy services).
- Reviewed the client's plans for ongoing Mental Health services through their current providers (community therapist, community psychiatrist/PCP).
- Obtained a Release of Information for this Specialist/Clinician to make contact with community therapist/community psychiatrist to discuss the client's recent crisis and recommendation for continued services.

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

Appendix O – Monthly Client Check-In for Medication Managers

Patient Check-In Call Template
Introduction:

- "Hi [Patient's Name], this is [Your Name] from SLO Behavioral Health. I'm calling to check in on how you're doing with your medication and overall health. Do you have a few minutes to talk?"

1. Updates:

- "Have there been any updates to your medical or psychiatric history?"
- "Have you been admitted to a psych facility or gone to the ER since we last spoke?"
    - "Can you tell me which hospital(s) and what your discharge medications were?"

2. Medication Compliance and Challenges:

- "Are you taking your medication as prescribed?" Would you say you are taking your medications 100% of the time? Between 50-99% or less than 50% of the time?
- "Have you had any trouble getting your medication or refills?"

3. Medication Consents:

- "Have we discussed verbal consent for your medication? Do you have any additional questions about the consent process?"

4. Symptom management:

- "What symptoms are your medications supposed to be helping with?"
- "Have you noticed that your symptoms are more or less intense? Or more or less severe than before you were taking medications?

5. Side Effects:

- "Have you experienced any side effects from your medication?"
- "Can you describe them for me?"

6. Concerns with Current Regimen:

- "Do you have any concerns about your current medication regimen?"

7. Mental Status Exam (MSE):

- The approach and focus shift slightly due to the lack of visual cues. Here' are examples of how to adapt each component:

Appearance (Indirectly Inferred)

    - Ask about their daily routine to gauge self-care.
    - Example: "Can you tell me about your day-to-day activities? How do you usually start your day?" "Have you been showering? Brushing your teeth? Doing your laundry?"

Behavior

- Listen for signs of agitation or unusual pauses.
- Example: “Have you felt restless or calm today?”

Speech

- Pay attention to the tone, pace, and coherence of speech.
- Example: “I noticed a change in how you’re speaking; is everything okay?”

Mood and Affect

- Directly ask about feelings and observe emotional tone.
- Example: “How have you been feeling emotionally this week?”

Thought Process

- Assess for logical flow and coherence in responses.
- Example: “Can you explain your thoughts on that a bit more?”

Thought Content

- Describe what the patient is talking about—are they hyper focused on one topic?

Hallucinations/Perception

- Inquire directly about hallucinations, delusions, and intrusive thoughts.
- Example: “Have you experienced any unusual thoughts or heard things others don't?”

Cognition

- Simple questions to assess orientation and memory.
- Example: “Can you tell me the current date and where you are?”

Insight and Judgment

- Ask about understanding their condition and decisions including if they understand why they take medications.
- Example: “How do you feel about your treatment plan? Have you made any important decisions recently?”

- Documentation Tips for Phone-Based MSE:

  - **Be Objective**: Record the patient’s verbal descriptions and your observations of their speech and responses.
  - **Be Detailed**: Provide specific examples from the conversation to support your observations.
  - **Be Consistent**: Use a standardized format for documenting phone-based MSEs.

8. Suicidal/Homicidal Ideation:

- “Have you had any thoughts of harming yourself or others?”

9. Baseline Lab Results (for medications like Clozaril or others that were ordered):

- "Have you completed your baseline lab tests?"
- "When was your last lab test?"

10. Substance Use:

- "How have you been taking care of yourself over the past month?"
- "Have you been using alcohol or drugs?"

11. Long-Acting Injection (if applicable):

- "Is your long-acting injection due soon?"
- "Do you need to schedule your next injection?"

12. Follow-Up with Provider:

- "Do you have any upcoming appointments with your provider?"
- "Do you need help scheduling a follow-up?

Closing:

- "Is there anything else you'd like to discuss or need help with?"
- "Thank you for your time. Please reach out if you have any questions or concerns before our next call."

Documentation:

Medication Support Progress Note Template for Medication Manager

Subjective/CC/HPI/Visit Notes Section
Reason for today's visit:
Ordering MN/DO/NP:
Medical/Psychiatric Updates: [Description]
Name of pharmacy (for refill verification):
Number of days refilled:
Number of additional refills placed:
Interval History (describe any relevant events since last visit, symptoms reported, adherence to medication, side effects):

- Medication Adherence: Percentage (100%, 50-99%, <50%) [Details]
- Symptom Management: [Well controlled/Not well controlled/details]
- Side Effects: [Description]
- Healthcare/Psychiatric Concerns: [Details]

Consents Discussed: [Client Acknowledged & Agreed]
Mental Status: [Summary]

- Appearance: General appearance, grooming, clothing.
- Behavior: Psychomotor activity, eye contact, gestures.
- Speech: Rate, volume, fluency.
- Mood: Patient's subjective emotional state.
- Affect: Observed emotional expression.
- Thought Process: Coherence, logic, and flow of thoughts.

- Thought Content: Suicidal, homicidal ideation, presence of delusions, auditory/visual hallucinations.
- Perception: Hallucinations or misperceptions.
- Cognition: Orientation, memory, attention.
- Insight/Judgment: Awareness and decision-making abilities.

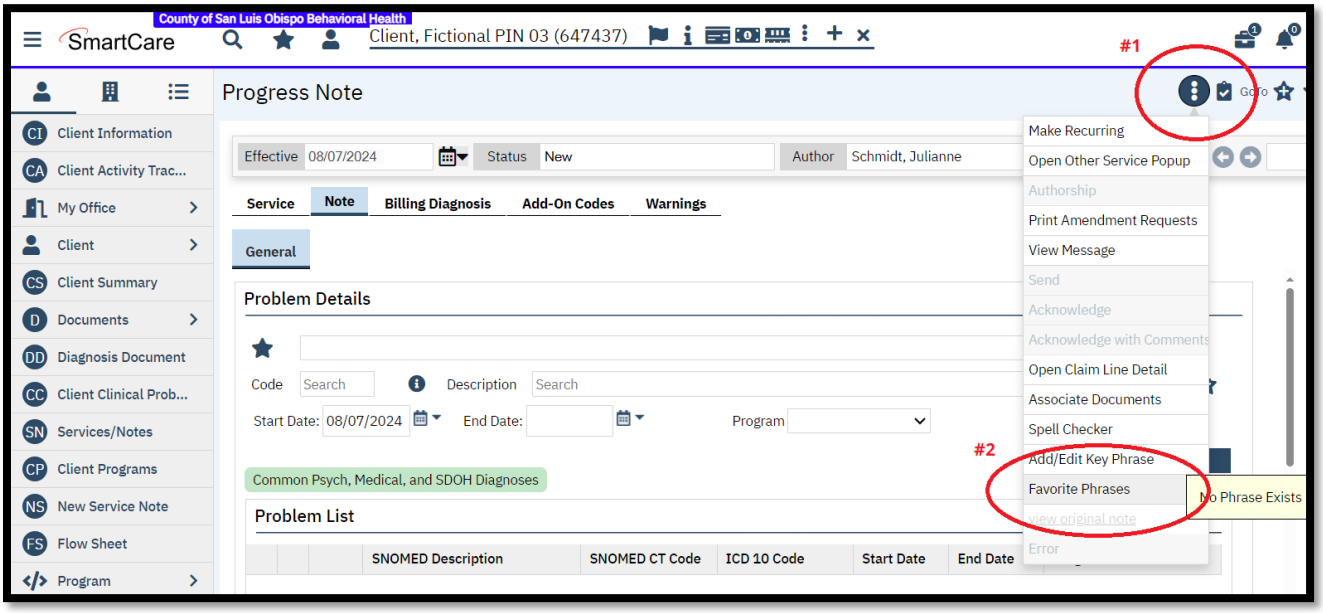
Suicidal/Homicidal Ideation and Risks: [Yes/No/Details]
Baseline Labs: [NA/Completed/Pending/Date]
Substance Use: [Yes/No/Details. Referrals + Education provided]
Injection: [NA/Due/Not Due]

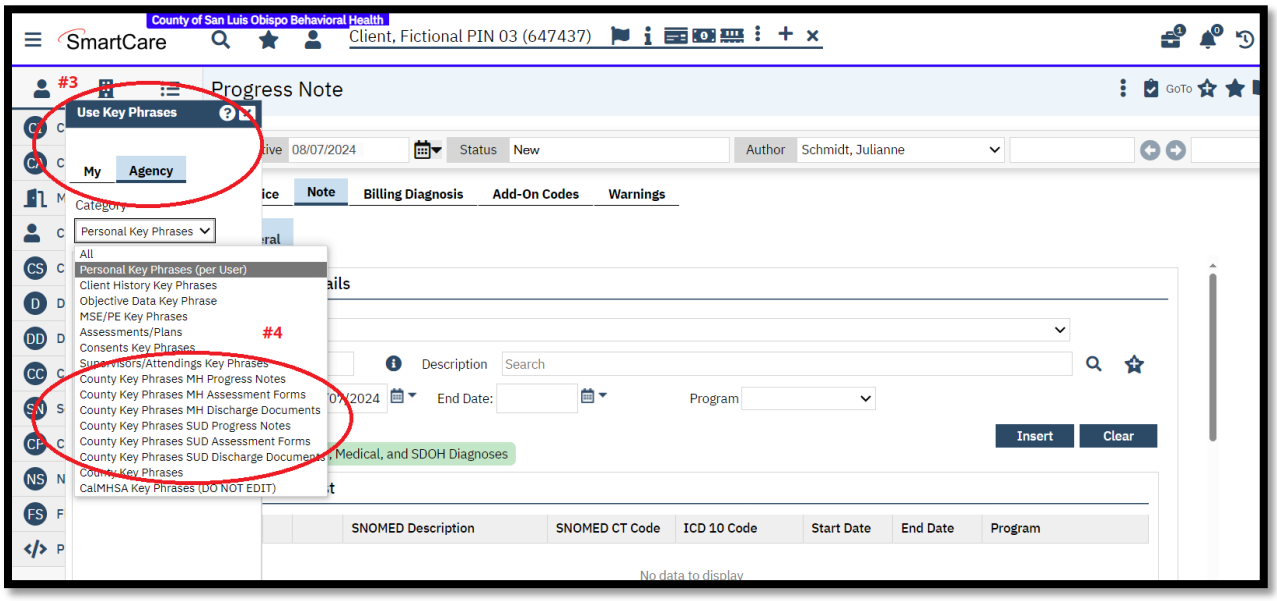
Medication Support Progress Note Template for Medication Manager
Assessment/Plan Section
Follow-Up: [Scheduled/Needs Scheduling]
Next Steps: [Referrals Provided/Needed]

Appendix P – Key Phrases

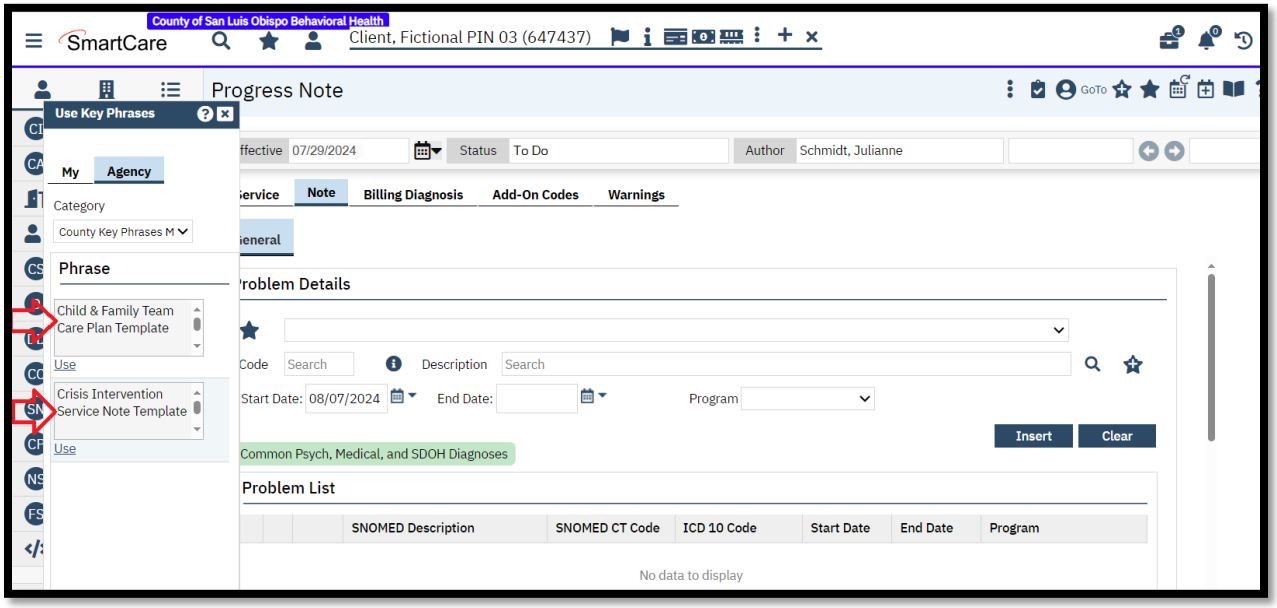
How to Use Key Phrases in SmartCare

- Key Phrases is what template text is called in SmartCare.
- Directions:
  - Open Client Chart
  - Start a new version of the documentation you are entering, whether that be a service note, an assessment, or a discharge summary.
  - Select the three dots icon (#1 below), and then select "Favorite Phrases" (#2 below). A new menu will open on the left side of your screen called "Use Key Phrases."
  - Select "Agency" (#3 next page), and then select the category of the key phrases you would like to view/use (#4 next page) from the "County Key Phrases" choices available.
  - Key Phrases have been developed that are Mental Health treatment specific (denoted by "MH" in the title) and Substance Use Disorder treatment specific (denoted by "SUD" in the title).





- Each Key Phrase available displays in a separate box (see arrows below). Each box has been titled to indicate what the template text is intended for.
- Put your cursor where you want the key phrase/template text to go. Then click the "use" link. The text will populate in the location you have chosen with your cursor.



- Delete template text that is not needed (directional template text).

Appendix Q – Document Signature Key

Document	Allowed Signatures by Scope/Title	Required Signatures
Diagnosis Form	• LPHA	• LPHA
Problem List	• MHRS (Specialist) • OQP (Specialist) • LVN/LPT • RN • LPHA (Clinician) • MD/DO	
CalAIM Assessment	• LPHA (Clinician) • Program Supervisor (Clinician)	• LPHA (Clinician) • Program Supervisor (Clinician)
CANS	Staff member completing the CANS must be CANS certified. • MHRS (Specialist) • OQP (Specialist) • LPHA (Clinician)	• HIT (required for processing)
PSC	• MHRS (Specialist) • OQP (Specialist) • LPHA (Clinician)	
Care Plan	• MHRS (Specialist) • OQP (Specialist) • RN • LPHA (Clinician) • MD/DO	
CalMHSA Discharge Summary		