Santa Cruz County CalAIM Guides: Updated Progress Note Guidance (MHP & DMC-ODS) – May 2024

Introduction

Mental Health Plan (MHP) & DMC-ODS Progress Notes

Progress notes are a communication tool used as a basis for documenting client care and treatment among practitioners and across programs. A CalAIM focus is to simplify progress note writing and ***decrease*** the time providers spend documenting services. Progress notes should provide a **brief** description of the interventions provided, client response, and planned next steps.

Progress Note Due Dates

Routine outpatient and residential service progress notes are to be completed within three (3) business days. State oversight has defined "**business day**" as any day a provider is open and provides services. The date of service = day 0.

Examples:

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

Crisis service notes are to be completed and finalized within ***one calendar day,*** regardless of program operating hours. The day of service shall be considered day 0.

Examples:

- Date of service = Monday, note must be finalized by end of day (EOD) Tuesday
- Date of service = Friday, note must be finalized by end of day (EOD) ***Saturday.***

If a progress note is late, the delay should be explained within the progress note. Do not share personal provider information in the note. Late notes should not occur frequently.

Acceptable reason: the provider's illness delays the completion of a note beyond the due date.

Note to state, "Late entry due to unexpected absence of clinician."

Acceptable reason: technical difficulties (such as clinician computer fails for 1-2 days).

Note to state, "Late entry due to technical difficulties."

*QI Fun Fact: this is why it is best to complete documentation early 😊

Progress Note Clarification of Requirements

Progress Note minimum requirements for narrative:

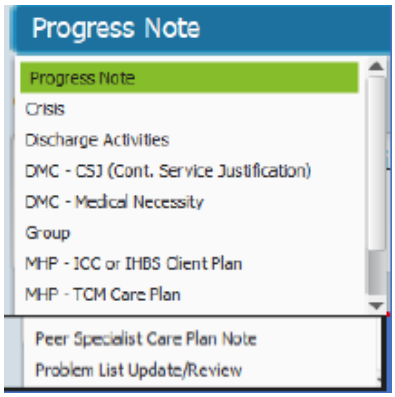
- Focus on the interventions and the services provided. Provide a brief description of how the service addressed client's behavioral health needs (symptoms, condition, diagnosis and/or risk factors);
- Include a brief summary of next steps;

Examples **may** include:

- Planned action steps by the provider ***or*** by the client/significant support person;
- Planned collaboration with other providers;
- Actions to address needs (including health, social educational, behavioral health of the client);
- Referrals provided;
- Discharge and continuing care planning.

Progress Note Types:

Be sure to select the correct **type** of progress note you are writing, including MHP TCM Care Plan, MHP ICC Client Plan, Peer Specialist Care Plan, Problem List Update, DMC-CSJ, DMC-Medical Necessity, Crisis, etc.



Progress note Tips:

- Notes should be easily understandable and avoid jargon and abbreviations
- Focus on interventions that addressed the client's needs
- The client has legal privilege to their medical record and may review the medical record documentation; notes should be understandable to the client
- If one practitioner provides the **same service type more than once in a day** (ex: two separate case management sessions on **same** day to **same** client), write one note to capture the services/cumulative time rather than separate notes.
- Specialty Mental Health providers ***are not limited*** to one service per day (except FQHC)

Progress Note Samples

DMC-ODS Plan Individual Counseling:

Intervention: Client reported ambivalence about treatment but wanting to meet probation requirements. Writer utilized motivational interviewing techniques to help client elicit change talk and increase motivation for staying in treatment. Client was receptive and decided to continue services.

Follow up Care/ Discharge Summary: Mike is scheduled for 3 group sessions per week, scheduled another individual session with him next week.

DMC-ODS Care Coordination:

Intervention: Writer returned phone call to client's Probation Officer who confirmed client's report of two positive drug screens for alcohol and marijuana. PO reports client is at risk of being remanded to jail if a third test is positive screen.

Follow up Care/ Discharge Summary: Will meet with client to discuss test results and provide motivational interviewing.

Mental Health Plan Targeted Case Management (Care Plan documented in previous note):
Intervention: Writer contacted Food Bank to gather information about how client can access free food, as currently they do not have financial resources for monthly food needs & cannot access this resource on their own due to disorganization Learned how to refer client to receive free food.
Follow up Care/ Discharge Summary: Plan to support client in obtaining food on a weekly basis from Food bank.

Mental Health Plan Rehabilitation:
Intervention: This writer facilitated mindfulness-based breathing exercise to assist client with strengthening stress management skills, which directly impacts their experience of depression symptoms. Writer taught deep breathing exercise and body relaxation techniques to client & coached client on using these skills when feeling stress. Encouraged client to continue practicing skills to manage symptoms of depression that include sadness.
Follow up Care/ Discharge Summary: Client will practice these skills during the next week. We will continue to meet once a week to develop and practice stress management techniques to alleviate depressive symptoms.

Mental Health Plan Therapy – NON-FQ:
Intervention: Checked-in with client using scaling questions to determine current level of anxiety. Explored what would make client's anxiety rating a point higher and a point lower. Writer asked exception-seeking questions to explore times in which client has experienced lower ratings of anxiety and explored what was different about those situations. Discussed how they would know if their anxiety was completely gone and what would be different.

Follow up Care/ Discharge Summary: Will continue to meet with client weekly to work towards therapy goal of decreasing anxiety.

Resources

- CalMHSA Documentation Guides: HERE
- Santa Cruz County CalAIM Information Page: HERE
- DHCS Behavioral Health Information Notice 23-068: Documentation Requirements: HERE
- For detailed information regarding progress notes and progress note completion, please review the CalMHSA Progress Note training module: HERE