SANTA CRUZ COUNTY BEHAVIORAL HEALTH QI INFORMATION NOTICE

TOPIC: CalAIM Updated General Purpose Progress Note

Avatar Forms: Changes and Users Affected

Date	10/5/2022
Avatar Form(s)	General Purpose Progress Note
Changes	A focus of CalAIM is to simplify progress note documentation to decrease the time providers spend documenting so they can focus more time on working with the person in care. (1) Progress notes are no longer *required* to be in DIRP (data, intervention, response, plan) format; **Narrative** and **Follow-up Care** are required. (2) Progress Note Type drop-down list has been expanded for both MHP and DMC-ODS (see below).
Users Affected	All Users writing Avatar Progress Notes, MHP and DMC-ODS

Progress Note Narrative FIELD	**LIGHT BULB**
Client Presentation (Optional)	Describe the client's presentation or any significant changes in functioning/behavior
Narrative Description of Service **(Required)**	Document "Travel time included" (if appropriate). **MHP & DMC-ODS:** Narrative description of the service, including how the service addressed the person's behavioral health (MH / SUD) need (symptoms, condition, diagnosis and/or risk factors) and the purpose of the service. Describe interventions utilized and how the person in care was included and participated. Include relevant description of the presentation of the person in care (unless already included in client presentation). Include progress towards problems on problem list and/or treatment plan if applicable. **DMC-ODS Additional Requirements**: Include start and end of documentation time; Indicate at least 1 EBP utilized; include that confidentiality was maintained if service was provided in the community. **MHP Residential Daily Note:** Describe how services provided during the day reduced impairment, restored function or prevented significant deterioration in functioning. Describe any progress made towards addressing problems identified on their problem list.

Progress Note Narrative FIELD	LIGHT BULB
	DMC-ODS Residential Daily Note: In addition to above, describe a summary of the services provided during that day, including all group and individual counseling sessions. For individual services, include the start & end time, EBP interventions utilized and how the service addresses the person's behavioral health (SUD / MH) related needs (e.g. symptoms, conditions, diagnosis and/ or risk factors). For group services, include the group name/title, purpose, start & end time, and group count for each group the person attends during that day. Document clinically relevant information, including how the person in care was included and participated. Describe any progress made towards addressing problems identified on their problem list.
Client Response to Intervention (Optional)	The client's response to the care provided, and the progress the client is making in treatment.
Referral to Community Services (Optional)	Referrals offered as appropriate; coordinated care contact info; status of referrals.
Follow-up Care / Transition Plan / Other Related Documentation **(Required)**	Follow-up Care: Plan for next steps based on client response to intervention, whether progress was made or not, adjustments needed to services. Transition Plan: Document the termination and/or transition of services with brief summary of services provided and reasons for closure with referrals offered as appropriate. *Note, does not replace the Treatment / Discharge Summary form Other Related Documentation for the chart.

Progress Note Type Field

NOTE TYPE	DEFINITION
Crisis	Crisis: Describe the crisis intervention service, including the interventions provided during the crisis service. Include your follow-up steps for coordination of care and safety planning. NOTE: Be sure to enter the start time and end time of your crisis service. Start time includes time from dispatch to meeting with the client. Is the crisis appropriate to update/add to the Problem List? *PN needs to be completed within 24 hours of the start of the crisis service. DMC-ODS Crisis= An actual relapse or an unforeseen event or circumstance, which presents to client an imminent relapse threat.

NOTE TYPE	DEFINITION
DMC-CSJ	**DMC-ODS Only:** Documentation of Continued Service Justification (CSJ) to be completed by an LPHA within 5-6 months of admission or last CSJ (NTP=12 months from admission date or last CSJ). NOTE: CSJ notes are now to include documentation by an LPHA that care coordination services are clinically indicated to provide as part of treatment.
Discharge Plan	**MHP and DMC-ODS:** Progress Note documenting discharge planning activities including care coordination activities associated with discharge.
DMC – Medical Necessity	**DMC-ODS Only:** Documentation of Medical Necessity by LPHA for current LOC. Review with program supervisor for program specific Medical Necessity timeline requirements set forth by DHCS/CalAIM or Federal regulations. NOTE: Medical necessity notes are now to include documentation by an LPHA that care coordination services are clinically indicated to provide as part of treatment.
Group	Group Note requirements: title of group, provider(s) and credential, total duration and per client duration, intervention, follow-up.
Problem List Update	Use this item to document when the problem list is updated, including when problems identified by staff, the person in care and/or significant support person, are added, removed or resolved from the Problem List.
Progress Note	This is the default note type for providing of general and ongoing services. Make sure to include your narrative description of services as well as follow-up steps, i.e what will you and/or the client do for follow-up.
MHP - TCM Care Plan	**MHP Only**: Use this item for a note that describes your plan for providing TARGETED CASE MANAGEMENT (TCM) services to your client. Describe TCM goals and activities, participation of the person in care, and the transition plan for when goals are achieved. Use this progress note type when creating the TCM Care Plan, and when updating / reviewing the TCM Care Plan to ensure the Plan still reflects current treatment. Then use “Progress Note” type for future services toward achieving the TCM Care Plan goal(s).
MHP - ICC/IHBS Client Plan	**MHP Only:** Use this item for a note that describes your plan for providing ICC or ICC & IHBS services to your client under the age of 21. Describe ICC/IHBS goals and activities, participation of the person in care / their family, and the transition plan for when goals are achieved. Use this progress note type when creating the ICC/IHBS Plan and when updating / reviewing the ICC/IHBS Plan to ensure the Plan still reflects current treatment. Then use “Progress Note” type for future services toward achieving the ICC/IHBS Plan goals.