Introduction

DMC-ODS Progress Notes

This document provides interim guidance for all **DMC-ODS** staff regarding writing progress notes that meet CalAIM standards. We are still working under the constraints of the ***current*** Avatar progress note form until it is updated. Until that update, the current Avatar progress note form will be used. Information regarding the ***updated*** Avatar progress note form can be found later in this guide. The ***updated*** progress note form is accessible now in Avatar **UAT**. Per request of supervisors, BH will not transition to use of the ***updated*** progress note form until September 19, 2022, to allow for staff time to review and learn about the new form prior to the form going live. Staff will be notified when the ***updated*** Avatar progress note form is active in Avatar LIVE.

Progress notes are a communication tool used as a basis for planning client care and treatment among practitioners and across programs. 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. Progress notes are to be lean; a progress note should provide an accurate picture of the person's condition, include the treatment / interventions provided, and their response to care at the time the service was provided.

Progress notes are ***no longer*** required to be in DIRP (data, response, intervention, plan) format. Services are to be documented in the narrative of the progress note and should reflect what is clinically indicated for the person in care.

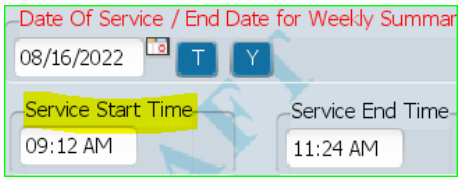
Progress Note Due Dates

The purpose of the progress note is to communicate information quickly, and to describe treatment provided. In order to facilitate prompt communication, CalAIM standard for ***routine*** outpatient and residential services is completion of the progress note 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. Routine outpatient and residential progress notes are to be completed and finalized within ***3 business days*** of the date of service. Progress note timeliness requirements are for the direct service provider who writes the progress note; for some providers, co-signatures may still be required.

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 ***24 hours*** of the start of the crisis service provided. Crisis service progress notes require the service start time and service end time to be included in the progress note.



The 24-hour "clock" begins at the service start time and ends when the note is finalized by the provider. **If a progress note is late, the delay should be an explained within the progress note.**

Group Progress Note Guidance

As of July 1, 2022, one group practitioner may document group facilitation by multiple practitioners. For groups facilitated by multiple practitioners, a single progress note signed by one of the practitioners shall be used to document the group service provided. Information about the specific involvement and specific amount of time of involvement of each practitioner in the group activity must be documented.

HOWEVER, the current Avatar group progress note form is not set up to bill for two facilitators' time in one group progress note. The avatar group progress note form will be updated to support this shift in practice. Until the group progress note form is updated in Avatar, please continue to have group facilitators document their own group progress notes for co-facilitation of a group to ensure both group facilitators' time is accounted for. QI will issue updated guidance around documenting more than one group facilitator's time and involvement in one group progress note once the avatar group progress note form has been updated.

General Progress Note Guidance & Tips

For detailed information regarding progress notes and progress note completion, please review the CalMHSA Progress Note training module and the CalMHSA Documentation Guides: HERE

Progress note Tips:

- Clear, concise, and easily understandable (avoid jargon and abbreviations)
- When possible, may include active participation and quotes from the person in care
- Focus on interventions that addressed the person in care's behavioral health needs (symptoms, conditions, diagnosis, risk factors)
- Include how problems on Problem List were addressed; include updates to the Problem List
- Include next steps for provider and person in care
- The person in care has legal privilege to their medical record and may review the medical record documentation; notes should be understandable so the client can recognize the treatment described
- May document co-occurring (mental health and substance use disorder (SUD) treatment with clinically appropriate services for a SUD condition in the presence of a co-occurring mental health disorder; services delivered shall be within the practitioner's scope of competence

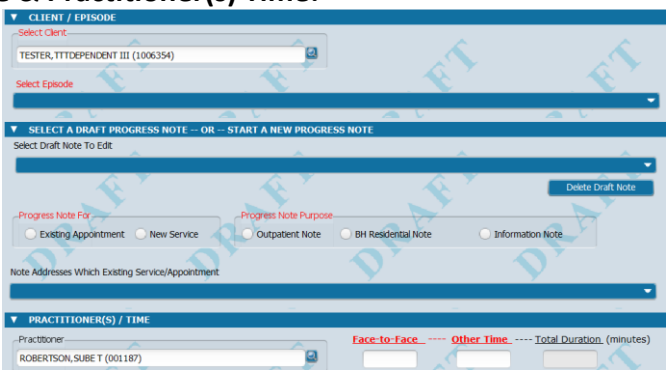
- If one practitioner provides multiple services of the **same service type** (ex: assessment, care coordination) to the same person on the same day, consider writing one note for a cumulative duration of time rather than separate notes (all services must have been provided by the same staff person)

How to Write a Progress Note in the Current Avatar Progress Note Form (Now until 9/19/22)

See "Future Avatar Progress Note" section later in this document for guidance on the updated Avatar progress note form; the updated progress note form is expected to go LIVE on September 19, 2022

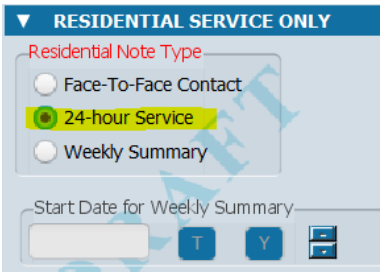
Current Avatar Progress Note Form Completion:

For Client / Episode & **Select Draft Progress Note** & **Practitioner(s) Time:**
All Levels of Care (LOC): No change



Residential Services Only Section:
All outpatient LOC: not applicable

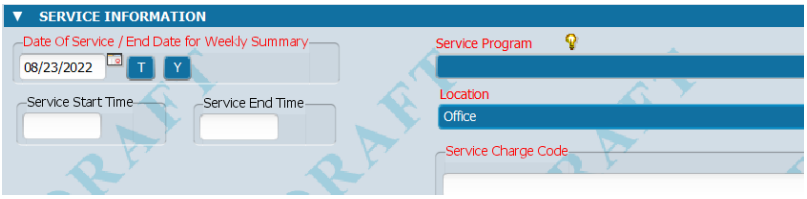
Residential / WM: Select 24-hour Service



For Service Information Section:
Crisis Service:
The 24-hour "clock" begins at the service start time and ends when the note is finalized by the provider
Complete:
Date of Service,
Service Start Time, Service End Time
Service Program, Location
Service Charge Code

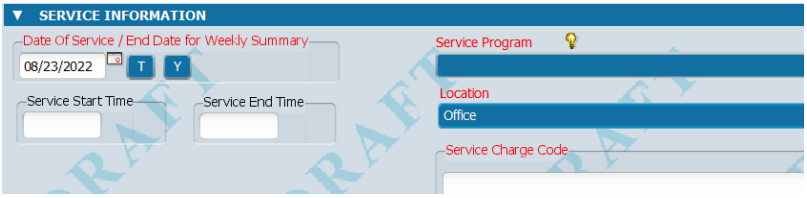
All Outpatient LOC/RSS:
Complete:

- Date of Service
- Service Program
- Location
- Service Charge Code



Service Information:
Residential (3.1 & 3.5)
WM (3.2)
Complete:

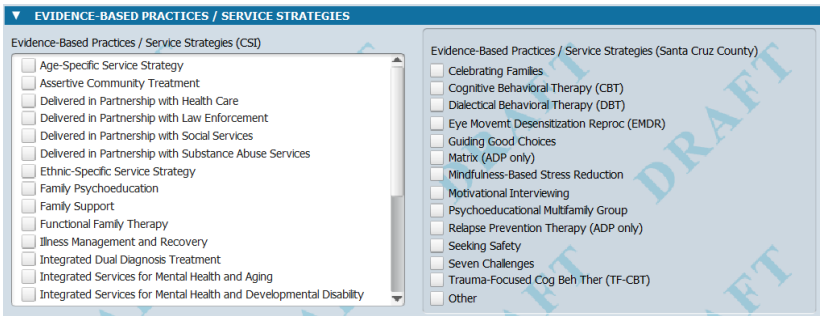
- Date of Service
- Service Program
- Location
- Service Charge Code: **A180** (Non-Billable Residential Summary) or **A001** Non-Billable Information) are acceptable



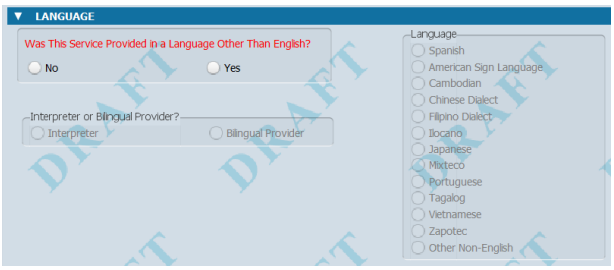
NOTE: See below for CHANGES to Service Charge Code for Residential & WM Programs

Evidence Based Practices (EBPs) / Services Strategies:

All LOC:
Select appropriate EBPs



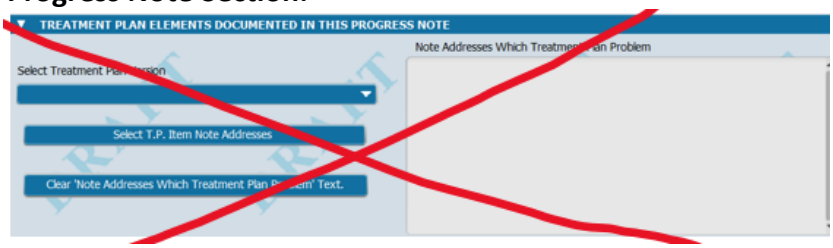
Language:
All Levels of Care (LOC): No change



Treatment plan Elements Documented In This Progress Note Section:

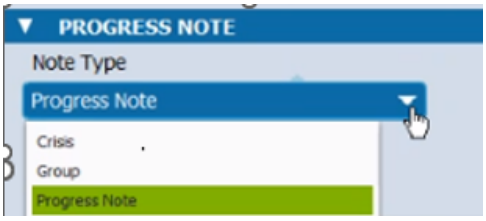
No longer included ***unless you are an NTP provider***.

Treatment plan information will no longer be pulled into the note for most services (NTP = exception).



Note Type:

All LOC: No change



Progress Note Content (Non-Residential):

Presentation: Not required, however Avatar will force you to write something.
You may write a brief client presentation here or write, "see intervention section."

Intervention (Narrative Description of Service):
Include documentation start and end time & that confidentiality was maintained if service was provided in the community. Include documentation of how at least one evidence-based practice (EBP) was utilized during the service.

Narrative description of the service, including how the service addressed the person's behavioral health (SUD / MH) 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. Include progress towards problems on problem list if applicable.

Response: Not required, however Avatar will force you to write something.
You may write a brief client response here or write, "see intervention section."

Referrals to Community Services: Not required.
You may include brief referrals provided.

Follow up Care/ Discharge Summary:
Include next steps, including but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other providers and any update to the problem list as appropriate.

Progress Note Content (Daily Residential):

Presentation: Not required, however Avatar will force you to write something.
You may write a brief client presentation here or write, "see intervention section."

Intervention (Narrative Description of Service):
Include documentation start and end time & that confidentiality was maintained if service was

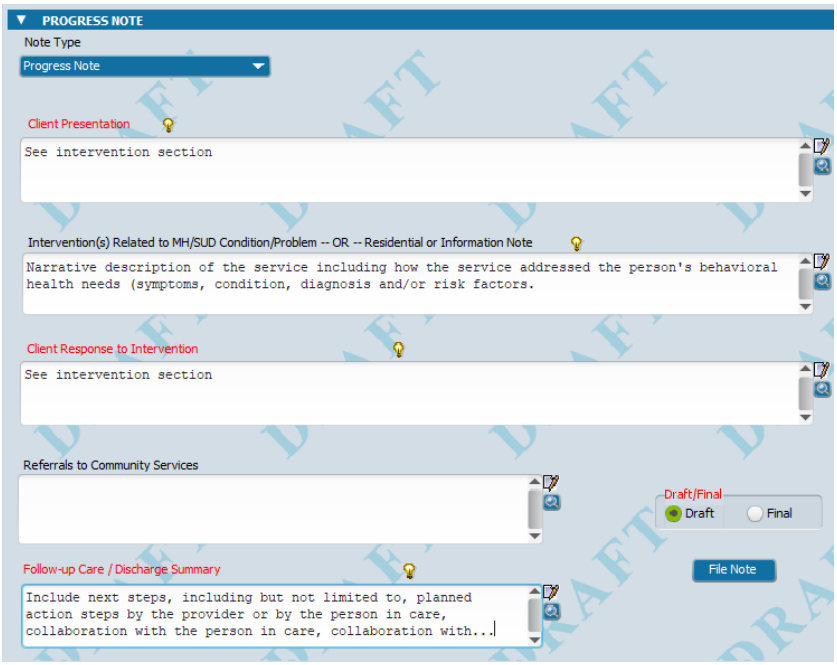
provided in the community. Include documentation of how evidence-based practices (EBP) were utilized.
Describe a summary of the services provided during that day, including all group and individual counseling sessions. For individual services, include the start & end time, interventions utilized and 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. Include relevant description of the presentation of the person in care. Describe any progress made towards addressing problems identified on their problem list.

Response: Not required, however Avatar will force you to write something.
You may write a brief client response here or write, "see intervention section."

Referrals to Community Services: Not required.
You may include brief referrals provided.

Follow up Care/ Discharge Summary:
Include next steps, including but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other providers and any update to the problem list as appropriate.



NEW !!

Residential and Withdrawal management (WM) Service Code Changes, effective September 19, 2022

Beginning on September 19, 2022, Residential and Withdrawal Management programs will discontinue the use of A001 / A180 non-billable codes and instead will utilize the Service Charge Code appropriate to their level of care & client age when documenting their daily progress note:

RES 3.1 = A1500 / A2500 (U21)
RES 3.5 = A1110 / A2110 (U21)
WM 3.2 = A1700 / A2700 (U21)

If clinician is unclear which service code to utilize, consult with your clinical supervisor for guidance.

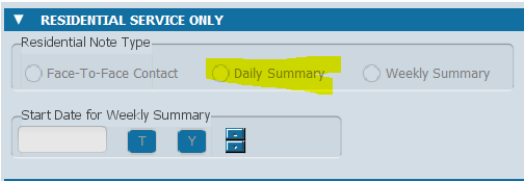
Updated Avatar Progress Note Form (Live September 19, 2022)

NOTES:
Progress note fields that are no longer required (client presentation & client response) must be kept in the updated form because if removed, we can no longer see them in past progress notes. We need to keep this historical documentation. Fields that are no longer required will be optional (no longer red).

In the Updated Progress Note form, *unless noted below*, fields will not change.
These fields will have the following CHANGES:

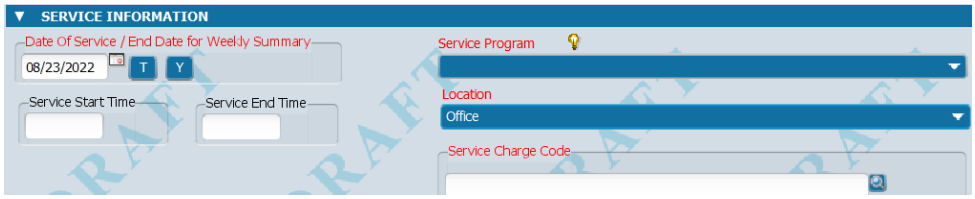
Residential Services Only Section:
All outpatient LOC /RSS: Not applicable

CHANGE: Residential/WM programs - Select Daily Summary button



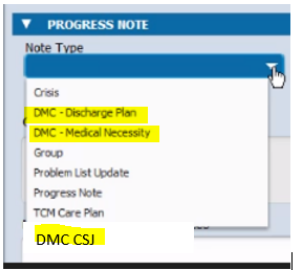
Service Information:
Residential / WM:

CHANGE: Use code appropriate to residential LOC & client age

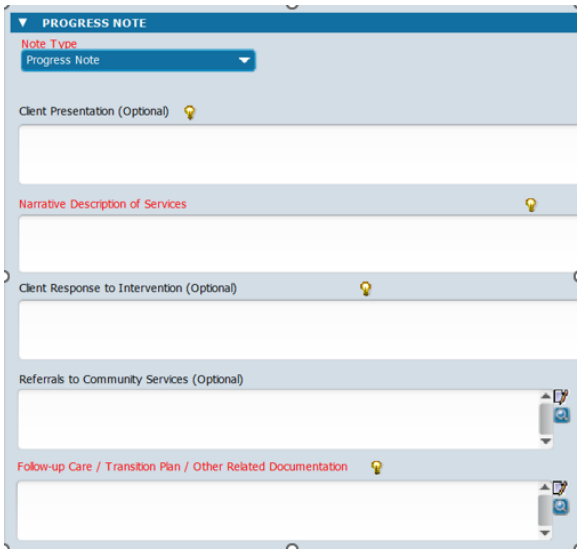


Note Type:
CHANGE: All LOC will select appropriate note type option for DMC-ODS.
Additional Note Types added:

- **DMC Discharge Plan**
- **DMC Medical Necessity**
- **DMC CSJ**



Progress Note Content:
All LOC:
CHANGE:
Required (red) fields updated: ONLY Narrative & Follow-Up Care will be required fields; other fields are optional and available for use as indicated



Progress Note Examples

Residential 3.1 Daily Summary:

Billable Service Code: A1500 (after 9/19/22, 21+ client)
Documentation time 2:15-2:35PM

Intervention: Staff used daily sign-in sheets and consulted with other residential staff to verify Mary's attendance/participation. Group facilitator utilized relapse prevention interventions to help assist Mary with identifying triggers and how to manage them in addition to utilizing seeking safety curriculum and CBT as part of group interventions. Mary is currently working on relapse prevention and recovery support in her problem list associated with ASAM dimensions 5 & 6. Mary has been engaged in group sessions and has been making progress towards addressing problems identified in her problem list.

Groups Included:
Women's Process Group (Clinical)
Time: 5-6PM; Topic: Seeking Safety: Setting Boundaries in Relationships
Purpose: To teach persons in care how to set healthy boundaries in relationships and learn how to recognize unhealthy boundaries; Group Count: 10

Group Name: Coping with Trauma (Clinical)
Time: 6:15-7:15PM; Topic: The Co-Occurrence of Trauma and Substance Use
Purpose: To assist persons in care with understanding the link between trauma/ SUD use, their effects on the body and brain and how to utilize cognitive behavioral therapy (CBT) techniques to develop healthy coping strategies; Group Count: 10

Group Name: Life Skills (Psychoeducational)

Time: 7:30-8:30PM; Topic: Money Management
Purpose: To teach persons in care about how to manage their money including strategies to developing a budget, grocery shopping on a budget and paying bills; Group Count: 26

Follow up Care/ Discharge Summary: Mary will continue to engage in residential treatment services by attending 2-4 60min groups per day in addition to at least one weekly individual session with their primary counselor. Primary counselor scheduled individual session with the Mary next week and will continue to work with her to increase her support network through participation in outside support groups.

Individual Counseling Note:
Billable Service Code: based on program, LOC and age of client
Documentation time 2:15-2:25PM
Intervention: Met with Mike for individual FTF counseling session in office. Documentation time 1:15-1:25PM. Mike reported being ambivalent about staying in treatment due to not feeling like he needed treatment**,** but also wanting to stay in treatment to meet the requirements of his probation. I utilized motivational interviewing techniques to help Mike elicit change talk and increase motivation for staying in treatment. Mike was receptive and decided to continue IOS services.

Follow up Care/ Discharge Summary: Mike is scheduled for 3 group sessions per week, scheduled another individual session with him next week in order to continue to support him with staying engaged in treatment.

Crisis Service Note:
Billable Service Code: based on program, LOC and age of client
Documentation time 2:15-2:30PM
Intervention: James reported that he felt highly triggered to use alcohol today due to a fight with his mother. Staff actively listened to James and provided supportive feedback as he processed his SUD crisis. Staff engaged client in inventory of their supports and a plan to avoid relapse; reviewed relapse prevention plan, focusing on coping skills when experiencing triggers.

Follow up Care/ Discharge Summary: James was able to identify some triggers and agreed to plan to check in via phone call before next scheduled treatment service. James also agreed to call his sponsor this evening to request additional support. Re-referred James to MAT services to address cravings that cause relapse & offered to call MAT services together to support linkage to that service.

Additional sample progress notes can be found in the CalMHSA Documentation Guides.

Resources

- CalMHSA Documentation Guides: HERE
- Santa Cruz County CalAIM Information Page: HERE
- DHCS Behavioral Health Information Notice 22-019: Documentation Requirements: HERE