Monterey County Behavioral Health
Quality Improvement
CalAIM Implementation Memo: 002

Re:	Documentation Reform: Clinical Progress Notes
Form Reference	Behavioral Health Information Notice No.: 23-068: Updates to Documentation Requirements for all Specialty Mental Health (SMH), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services.
Effective	7/1/2022
Revised	2/5/2024

Topic

In the spirit of California Advancing and Innovating Medi-Cal (CalAIM), Monterey County Behavioral Health is moving forward with implementing the new documentation requirements for progress notes for Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMS-ODS).

Procedure

1. **Effective 7/1/2022**.
2. The current progress notes forms being used to document SMHS and DMC-ODS are NOT changing.
3. All providers shall create progress notes for each service and shall provide sufficient detail to support the service.
    a. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation). **Weekly summaries will no longer be required for day rehabilitation, day treatment intensive, adult residential, crisis residential, and SUD Residential 3.1/3.5.**
4. Providers shall complete progress notes within 72-hours of providing a service, with the exception of notes for crisis services, which shall be completed within 1 calendar day.
5. Progress Note requirements are as follows:
    a. The type of service rendered: this is the service code description;
    b. The date that the service was provided to the beneficiary;
    c. Duration of the direct service, travel, and documentation;
    d. Location/place of the service (note, the location/place of services refers to the location/place of the beneficiary while receiving the service, however, if the service is telehealth/telephone, use the telehealth option)
    e. A brief description of how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors); and
    f. A brief summary of next steps. For example, as clinically indicated next steps may include planned action steps by the provider or by the person in care; collaboration with the beneficiary; collaboration with other provider(s); goals and actions to

address health, social, educational, and other services needed by the member; referrals; and discharge and continuing care planning.

6. The county does not require a specific progress note format (i.e. FIRP, BIRP, SOAP), however items 5a-f must be clearly documented in the progress note.
7. NOTE: Group Progress Notes – Each beneficiary that attended the group service must have a progress note. At this time, the group progress note process will not change in AVATAR and staff shall continue to follow the current group progress note process.
    a. Group progress notes shall include the information listed in 5a-f above
    b. Group progress notes shall also include a brief description of the beneficiary's response to the service. For example, as clinically indicated, the individual note for a group service may address the effectiveness of the intervention; progress or problems noted; group dynamics; or other information relevant to the beneficiary's participation, comments, or reactions during the treatment session.

Progress Note examples:

Assessment
This clinician conducted an initial intake assessment with client. This clinician gathered information about the reason for seeking treatment, from the client's perspective. This evaluation led to a determination that symptoms and impairments are consistent with a provisional diagnosis of Generalized Anxiety Disorder. Client was verbal and engaged throughout the session. Clinician will complete assessment documentation and problem list for review at next session. Next session planned in one week.

Case Management
Client is receiving mental health treatment in hopes of achieving their goal to find a way to cope with his voices and depression so that he can return to work. Writer will continue to support client through case management services to address the multi-dimensional needs identified in the assessment until the service goals are met or when there is no longer a need. Writer met with client to provide case management related to employment attainment. Writer supported client by contacting the Employment One-Stop Center and making an appointment for resume development. Upon achievement of the service goals, writer will provide care coordination and/or discharge planning to assist client in sustaining their gains. Client agrees with this plan.

Individual Therapy
Client continues to violate the terms of her probation and is engaging in high-risk behaviors (e.g., illicit substance use, high risk sexual behavior). In order to convey concern for client, this clinician inquired about her wellbeing and recent behavior. This clinician plans to continue to meet with client weekly to work toward increasing her ability to manage her impulsive and high-risk behavior.

Plan Development/Problem List
I collaborated with client to develop his initial problem list. Client was engaged throughout the session, though he struggled to identify strengths. Client was in agreement with the problem list developed. This clinician will begin individual and family therapy sessions later this week.