CLINICAL DOCUMENTATION GUIDE

2016

Yolo County
Health and Human Services

Collaborative
Accountable
Respectful
Equitable
Strategic

Yolo County MENTAL HEALTH PLAN
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Chapter 1: INTRODUCTION/COMPLIANCE

1.1. WHY DO WE HAVE THIS MANUAL?

This manual has been developed as a resource for outpatient behavioral health providers in Yolo County. It outlines the clinical documentation standards and practices required by the Yolo County Health and Human Services Agency (HHSA) Mental Health Plan (MHP). As a behavioral health system, it is our mission to provide high quality, culturally competent services and supports that enhance recovery from substance use disorders, serious mental illness, and serious emotional disturbance. Our vision is to promote the overall well-being, recovery and health of individuals and families in our community. Specialty Mental Health services and interventions are designed to reduce mental disability and/or facilitate improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency.

Part of promoting resiliency and recovery is good documentation. There’s a saying throughout the healthcare industry that “if it isn’t documented, it didn’t happen”. In order to give evidence that the services provided by the Yolo County MHP and partner agencies reflect the values stated above, solid documentation practices must be followed. This clinical documentation guide serves to ensure that behavioral health providers within Yolo County meet regulatory and compliance standards of competency, accuracy, and integrity in the provision and documentation of their services.

As with any manual, updates will need to be made as policies and regulations change. As this is a living document, please be sure to replace old sections as updated sections are distributed. **Sources of Information:** This Clinical Documentation Guide is to be used as a reference resource and is intended for use during clinical documentation trainings and supervision. The reader is strongly encouraged to contact the Quality Management Team if additional clarification or interpretation of this guide is required. This manual includes information based on the following sources: Code of Federal Regulations (CFR) 42 and 45; California Code of Regulations (CCR) Title 9; California Department of Health Care Services’ (DHCS) Letters and Information Notices; Yolo County HHSA policies & procedures, directives, and memos; and the Quality Management Unit’s interpretation and determination of documentation standards. Readers are encouraged to review the manual thoroughly and refer to it during trainings and supervision.

**We welcome your feedback, questions, and concerns.** Please contact the Quality Management Team with your input and questions at [HHSAQualityManagement@yolocounty.org](mailto:HHSAQualityManagement@yolocounty.org).

Thank You,
The Quality Management Team
1.2. COMPLIANCE

The Yolo County Mental Health Plan provides services to the community and contracts with local providers, then seeks reimbursement from state and federal funding sources. There are many rules associated with billing the state and federal government, thus the need for this documentation guide. In general, good ethical standards meet nearly all of the requirements. At times, there is a need to provide some guidance and clarity so staff can effectively and efficiently document the services they provide.

Yolo County HHSA has adopted a Compliance Unit based on guidance and standards established by the Office of Inspector General, U.S. Department of Health and Human Services. The Office of Inspector General (OIG) is primarily responsible for Medicare and Medicaid fraud investigations and provides support to the US Attorney’s Office for cases which lead to prosecution. The State of California also has a Medicaid/Medicare Fraud Control Unit. Many California county behavioral health departments have already been investigated by state and federal agencies, and in all of those counties either severe compliance plans or fraud charges have been implemented. The intent of the compliance plan is to prevent fraud and abuse at all levels. The compliance plan particularly supports the integrity of all health data submissions, as evidenced by accuracy, reliability, validity, and timeliness. As part of this plan we must work to ensure that all services submitted for reimbursement are based on accurate, complete, and timely documentation. It is the responsibility of every provider to submit a complete and accurate record of the services they provide and to document services in compliance with all applicable laws and regulations. This guide reflects the current requirements for direct services reimbursed by Medi-Cal Specialty Mental Health Services (Division 1, Title 9, California Code of Regulations (CCR)) and serves as the basis for all documentation and claiming by HHSA, regardless of payor source. All staff in County Units, contracted agencies, and contracted providers are expected to abide by the information found in this guide. All staff are required to sign the Clinical Documentation Guide Attestation. (Appendix A)

Compliance is accomplished by:

- Adherence to legal, ethical, code of conduct and best-practice standards for billing and coding, and documentation
- Participation by all providers in proactive training and quality improvement processes
- Providers working within their professional scope of practice
- Having a Compliance Plan to ensure there is accountability for all HHSA and Contract Providers’ activities and functions- this includes the accuracy of progress note documentation by defined practitioners who will select correct procedures and service location to support the documentation of services provided

Compliance related questions, concerns, or reports can be directly made to the HHSA MHP
Compliance Officer:
Rita Samartino
rita.samartino@yolocounty.org
137 N. Cottonwood, Suite 2500, Woodland, CA 95695

Email the Compliance Officer or call anonymously through our 24-hour Compliance Reporting Line: 1 (800) 391-7440
2.1 GENERAL PRINCIPLES OF DOCUMENTATION

1. All Providers must refer and adhere to HHSA Policy QM-MH-0201, Progress Notes/Documentation Standards. (Appendix A)

2. Until the Electronic Health Record (EHR) is completely electronic, HHSA continues to maintain a hybrid health record system, which includes both paper-based and electronic documents. For new client admission and re-admission in Avatar, the hybrid health record continues to include chart forms that require client’s signature until systemwide implementation of signature pads and/or scanning capabilities. Signed forms are to be filed in the paper-based chart and scanned into the EHR.

3. All Providers must use HHSA approved forms or an approved electronic health record system for documentation. HHSA Contract Providers must incorporate all HHSA required documentation elements as referenced in this Manual and adhere to the forms / guidelines identified in HHSA Policy.

4. Required documents include an accurate and timely Assessment, Client Treatment Plan, and on-going Progress Notes. Remember that medical records, both electronic and paper, are legal documents.

5. Only services that have been entered in Avatar, or claims with accompanying progress notes for any programs not using Avatar, can be claimed.

6. All services shall be provided by staff within the scope of practice of the individual delivering service. See Chapter 6 for Scope of Service delineation. Practitioners shall follow specific scope of practice requirements as determined by the applicable license regulations of their governing board.

7. Progress Notes shall provide enough detail so that other service providers and auditors can easily ascertain the client’s status and needs, and understand why the service was provided without having to refer to previous Progress Notes. In other words, each Progress Note shall be a “stand-alone” note.
8. Each Progress Note must show that the service was "**Medically Necessary**": Progress Notes should clearly indicate the type of service provided and how the service is medically necessary to address an area of functional impairment identified in the Client Treatment Plan, and the progress (or lack of progress) in treatment. Describe unresolved or ongoing issues from previous contacts, and response to interventions.

**Practitioners shall document:**

- How the intervention provided relates to the clinical goals written in the Client Treatment Plan
- Addresses functional impairment and/or links to the mental health condition written in the Client Treatment Plan

Remember, a “medically necessary” service is one which attempts to impact a functional impairment brought about by a symptom of an included diagnosis (Please see Chapter 3 for a list of included diagnoses).

9. It is crucial that the staff providing the service records the correct procedure (e.g., treatment code) for the service provided and that the documentation supports and substantiates this service. In order for Yolo County to receive the correct reimbursement for services provided, practitioners must ensure that they choose the correct procedure for the correct Unit Facility/Unit and for the correct client.

10. It is also crucial that staff document each of the following components of time in each Progress Note in Avatar:

   a. **Start Time**: the exact time when staff begins working directly with a client, in person or via telephone. For example, if a 2:00 pm appointment begins at 2:03 pm, the staff shall document a Start Time of 2:03 pm.

   b. **Direct Service Time**: the total amount of time staff spends providing a service to the client, collateral contact, or completing a supportive case management activity.

   c. **Documentation Time**: the amount of time staff spends writing the Progress Note. *Documentation Time is an activity that is billable to Medi-Cal, but not to Medicare.*

   d. **Travel Time**: the amount of time staff spends traveling from the worksite to the client and back again to the worksite. Time spent traveling to/from a staff’s home from/to a client is not considered “travel time” for these purposes and may not be claimed. *Travel Time is an activity that is billable to Medi-Cal, but not to Medicare.*

   e. **Total Time**: the sum of Direct Service, Documentation and Travel Time. This will automatically populate in Avatar based on these entries. Please remember to bill for “actual” time spent providing a service to or for/on behalf of the client. Do not arbitrarily bill a “block of time” (e.g., an hour for each individual therapy or ten minutes for charting).

   f. **Face to Face (FTF)**: defined as the service provider and the client being in the same physical location. Services provided via telemedicine or over the phone, even if provided directly to the client, do not constitute FTF time. Medicare will only reimburse for FTF services.
11. Other critical components to appropriately select in each Progress Note in Avatar:
   
a. Client: Ensure selected client matches their medical record number
b. Episode: Select the appropriate open episode
c. Service Unit: Clarify the Medi-Cal certified site where service was provided or to which site client is assigned to if the service was provided in the field
d. Location: Delineate a place of service based on location (ex: office, field, jail)
e. Note Type: Based on each provider’s classification
f. Client’s Preferred Language: Select client’s preferred language

12. Frequency and timeliness of Service Documentation. Each service contact is documented in a Progress Note and documentation must be finalized in a timely manner, as defined below. Different types of services require different frequency of documentation. As per HHSA Policy QM-MH-0201, Progress Notes / Documentation Standards. (Appendix A):

**Frequency:**

- The following services require a Progress Note for every service contact:
  - Mental Health Services
  - Medication Support Services
  - Crisis Intervention
  - Targeted Case Management
- The following services require a Progress Note on a daily basis:
  - Crisis Residential
  - Crisis Stabilization (1 x 23 hours)
  - Day Treatment Intensive
- The following services require a Progress Note on a weekly basis:
  - Day Treatment Intensive (in addition to daily Progress Note)
  - Day Rehabilitation
  - Adult Residential
- The following services require a Progress Note for every shift:
  - Psychiatric Health Facility (PHF)

**Timeliness:**

- Every effort should be made to complete Progress Notes on the same date of the encounter/service activity
- Progress Notes shall be entered into Avatar on the same date of the encounter/service activity or within five (5) business days
• Progress Notes entered after five (5) business days shall be considered “Late Entry,” the practitioner shall write “Late Entry” in the beginning of the Progress Note

13. Documentation must be readable and legible. Ensure that the spell check function is turned on. In Avatar, the “spell check function” button is located near the bottom of the page. Always spell check prior to finalizing a document.

**Spell Check Function is within the Text Editor in Avatar and can be utilized by clicking on the clipboard with the pencil icon. Click on the orange A with a blue check icon.**

14. The use of abbreviations in clinical documentation must be consistent with approved HHSA abbreviations. (See Appendix B – Standard Abbreviations for a list of approved abbreviations.)

15. Restriction of Client Information: APS/CWS Reports, Incident Reports, Sentinel Events, Unusual Occurrence Forms, Grievances, Notices of Action, Change of Provider, Utilization Review Committee recommendations or forms and audit worksheets shall not be scanned into the electronic health record, or filed within the paper record and are not billable to MediCal or MediCare. No Progress Note should be completed for these activities with the exception of recommended practice to write a note for APS/CWS Reports. Questions regarding other forms (not already listed) and their inclusion into the medical record should be directed to QM staff.

16. Confidentiality: Do not write another client’s name in any client’s chart, whether paper or electronic. If another client must be identified in the record, (such as the family member of the client who is also receiving services), do not identify that individual as a behavioral health client. Names of family members/support persons should be recorded only when needed to complete intake registration, financial documents, Client Treatment Plans, and releases of information. Otherwise, refer to the relationship - mother, husband, friend, but do not use names. First names or initials of another person when needed for clarification are acceptable.

17. Copy and Paste: Do not copy and paste notes into a client’s medical record. Each note needs to be specific to the service provided. If using an Avatar template that brings forward text from the previous note, the narrative must be changed to reflect the current service being documented. Progress notes that are submitted which appear to be worded exactly alike, or too similar to, previous entries may be assumed to be pasted, e.g., containing inaccurate,
outdated, or false information. Claiming associated with such notes could be considered fraudulent.

2.2 SIGNATURES

A Practitioner signature is a required part of most clinical documents. In an EHR, the signature is electronic. In order to be able to sign documents electronically, the following are required:

- Your signature must be on file in order to use the Electronic Health Record (EHR). Avatar maintains a file of staff’s unique identifiers/signatures.
- Authentication – HHSA maintains a signed Electronic Signature Agreement outlining the terms of use for an electronic signature, signed by both the individual requesting electronic signature authorization and the MHP Director or designee. Electronic signatures based on login name and passwords are valid for six (6) months. Renewal of the password renews the electronic signature agreement.
- Agencies wanting to use their own electronic signatures must provide HHSA with policies and procedures on electronic signatures. Otherwise, a written signature must be documented on every Progress Note, Assessment and Client Treatment Plan.

*Each practitioner signature must include a license or designation (e.g., ASW, MD, MFT Intern, LCSW, MFT, MHRS, MHW, PhD waived, etc.)*

Co-Signatures

Co-Signatures for staff may be required on documents for several reasons. The State Department of Health Care Services (DHCS) requires that some documents, e.g., Client Client Treatment Plans, be approved by a Licensed, Registered, or Waivered Clinician. Additionally, County policy requires that some documents be reviewed and co-signed by a supervisor or a Licensed, Registered, or Waivered Clinician as part of the authorization process. Also, some staff are required to have Progress Notes co-signed for specific or indefinite periods. Other co-signature requirements may be assigned for purposes of quality assurance and/or compliance. Staff should consult with their supervisor for additional specifics. When a co-signature is required, a practitioner will be unable to file a document as “final” until said co-signature has been obtained.
3.1 THE FLOW OF CLINICAL INFORMATION

There is a flow of information designed to evaluate the need of each client coming in to start or renew their services. This process assists staff in evaluating medical necessity and support, in the provision of appropriate/available services clients need to meet their recovery goals.

1. The Clinical Assessment is the first step toward establishing medical necessity and the start/reauthorization of services. The Clinical Assessment identifies needs and informs the Clinical Formulation/Disposition, Diagnosis, Client Client Treatment Plan, and the services provided, as well as further supports the medical necessity for a client to receive services. The assessment is critical for establishing the diagnostic impression and identifying functional impairments.

2. The Diagnosis (based on DSM-IV TR/DSM-5) summarizes the areas of need, challenges, symptoms, and impairments; and provides the ICD-10 code required to submit a claim for each service rendered.

3. The Client Treatment Plan is a collaborative effort with the client and support persons, as appropriate, in identifying the client’s strengths, resources, challenges, barriers, and personal life goals. It provides a framework for clients to best understand and consent to the objective of services and interventions to be provided in order to best assist them in achieving stability, progress, wellness, recovery, and independence. The Client Treatment Plan takes the information
gathered during the assessment process and directs the focus of services. The Client Treatment Plan also links the interventions to the functional impairments of the client.

4. Each service provided links back to address the behavioral health issues identified in the Clinical Assessment, Formulation, Diagnosis, and Client Treatment Plan. The Client Treatment Plan clearly states how each intervention will address one or more identified functional impairments.

3.2  MEDICAL NECESSITY

Medical necessity is established through the flow of clinical information process. Medical Necessity must be determined during the initial and renewal authorization of services, must be well documented per each service provided, and must be continually evaluated through the course of treatment. Every service provided to the client/family is justified and supported as a “medically necessary” component of the behavioral health treatment to support the client/family in their path to recovery. Primary “Included” Diagnoses which are clearly supported by symptoms and resulting functional impairments further strengthen and reaffirm Medical Necessity- the need for behavioral health treatment and services. The Progress Note describes the specific interventions and services provided, and establish that the interventions and services are meant to address the functional impairment in keeping with the Client Treatment Plan. (See Appendix B for complete list of Included Diagnoses)

A medically necessary service is one which attempts to impact a functional impairment brought about by a symptom of an included diagnosis.
During the assessment process, the clinician should identify the client’s areas of life functioning which are impacted by their behavioral health, e.g.:

- Problems with primary group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to healthcare services
- Problems related to interaction with legal system/crime
- Other psychological or environmental problems

### 3.3 COMPONENTS OF MEDICAL NECESSITY

To be eligible for Medi-Cal reimbursement for outpatient Specialty Mental Health Services (SMHS) or services provided to Seriously Emotionally Disturbed (SED) youth, the service must meet **all three criteria for medical necessity** (Title 9, CCR §1830.205, Welfare & Institutions Code 5600.3):

**Diagnostic Criteria**

1. **Specialty Mental Health Services**: the focus of the service should be directed to functional impairments related to an Included Diagnosis.

   DSM-IV Disorder. Must have one (1) of the following disorders:

   a. Pervasive Developmental Disorders, except Autistic Disorders
   b. Disruptive Behavior and Attention Deficit Disorders
   c. Feeding and Eating Disorders of Infancy and Early Childhood
   d. Elimination Disorders
   e. Other Disorders of Infancy, Childhood, or Adolescence
   f. Schizophrenia and other Psychotic Disorders
   g. Mood Disorders
   h. Anxiety Disorders
   i. Somatoform Disorders
   j. Factitious Disorders
   k. Dissociative Disorders
   l. Paraphilias
   m. Gender Identity Disorder
   n. Eating Disorders
   o. Impulse Control Disorders Not Elsewhere Classified
   p. Adjustment Disorders
q. Personality Disorders (except Anti-Social Personality)
r. Medication-Induced Movement Disorders related to other included diagnoses

(See Appendix B for complete list of Included Diagnoses)

Clients may receive services if they have an excluded diagnosis as long as an included diagnosis is also present and the included diagnosis is the primary focus of treatment. Practitioners are expected to include any substance related diagnosis (as a secondary diagnosis) when warranted. It is recommended to include a secondary substance related treatment goal if it is relevant and related to the primary focus of treatment.

2. **Impairment Criteria:** The client must have at least one of the following as a result of the mental disorder(s) identified in the diagnostic criteria:

a. Significant impairment in an important area of life functioning, or

b. Probability of significant deterioration in an important area of life functioning, or

c. Children demonstrating a probability they will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder that can be corrected or ameliorated.

3. **Intervention Related Criteria:** Must meet all conditions listed below:

a. The focus of the proposed intervention is to address the condition identified in impairment criteria above, and

b. It is expected that the proposed intervention will benefit the client by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning; and/or for children it is probable the child will be enabled to progress developmentally as individually appropriate (or if covered by EPSDT, the identified condition can be corrected or ameliorated), and

c. The condition would not be responsive to physical healthcare based treatment.
4.1 ASSESSMENT

The Assessment is more than an information gathering process. The Assessment is a step towards building a trusting and therapeutic relationship between client and service provider/agency. It is also the start of understanding and appreciating the client’s self and worldview, and the interrelationship between the client’s symptoms/behaviors and the client as a whole person.

The initial assessment is an important first step to get a clear account of the client’s current problems. Providers have a responsibility to fully understand the individual and family, their strengths, abilities, and past successes, along with their hopes, dreams, needs, and problems with obtaining or maintaining stable community integration. Attending to the issues of culture in the process of the assessment is critically important. The provider must understand how culture and social context shape an individual’s and family’s behavioral health symptoms, presentation, meaning and coping styles along with attitudes towards seeking help, stigma and the willingness to trust.

The assessment can be completed in one contact or over the course of several contacts. See Section 5.1.1 for an example note.

Assessment Elements

The assessment must contain the following 12 elements:

1. **Presenting Problem:** identifier (gender, age, language spoken, identified race/ethnicity), current symptoms/concerns, frequency, severity, and examples, primary diagnosis provided by treating psychiatrist, functional impairments and difficulty in daily living, reported challenges/problems and other relevant conditions affecting physical and mental health status (stressors, trauma anniversaries, co-morbid medical/SUD issues, poor social support), **cultural and linguistic factors** and current implications from past trauma exposure

2. **History of Presenting Problem:** onset, precipitating events and/or stress, trauma, attempts at coping (include maladaptive and inappropriate means), mental health history, previous treatment dates, previous providers, therapeutic interventions and responses, sources of clinical data, relevant family information (family history of mental health and SUD issues), lab tests, history of difficulty in functioning, warning signs of possible decompensation, and consultation reports
3. **Social History:** current living situation (housing issues), history of living situation (born, raised, communities lived in), physical/emotional/sexual abuse, marital history (status, children), employment history, social support network, school history (Special Education, grade completed, literacy level), relevant family dynamics (guardian, siblings, closest with and current connections, and family structure), Personal Resources (strengths, skills, talents, abilities, preferred activities, intrinsic source of motivation)

4. **Psychiatric History:** previous providers and past hospitalizations (place, location, date, duration, response to treatment)

5. **Legal:** past/present probation, parole, incarceration, CPS involvement, conservatorship status

6. **Support Services:** outside agencies, in-home support, home delivered meals, CWS, regional center, AA/NA, Alta Regional Center, Church groups, Spiritual/Religious affiliation, SSI/SSDI/GA benefits, payee services, Medi-Cal/Medicare benefits, pharmacy (bubble pack meds, delivery service),

7. **Relevant Medical History:** physical health conditions reported by the client are prominently identified and updated, diagnosed medical problems, hospitalizations, surgeries, illnesses, allergies (sensitivities, known drug allergy), Name and contact information for primary care physician and specialists, date of last physical, scheduled follow up; For children and adolescents, prenatal events, and complete developmental history;

8. **Medications:** names, dosage, side effects, adverse reactions, frequency or Rx and OTC medications, relevant past Rx, dates of initial prescription and refills, and informed consent(s), alternative medicines

9. **Substance Abuse:** past and present use of tobacco, alcohol, and caffeine, as well as, illicit, prescribed, and over-the-counter drugs; Current Stage of Change;

10. **Special Status Situations:** suicidality (past, present, plan description, attempts/gestures, methods, safety plan), violence (assault, spousal abuse, child abuse, property damage, drug related), grave disability (hx of restoration, hx or current conservatorship status)

11. **Mental Status Examination:** appearance, speech, affect and mood, thought, perception, memory, intellect, insight, somatization

12. **Full five-axis Diagnosis:** consistent with the presenting problems, history, mental status examination and/or other clinical data

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**Clinical Formulation**

**Disposition, Recommendations, Referrals, Summary and Timeliness of Assessment**

It is strongly suggested that the Initial Clinical Assessment is completed and submitted for review and co-signature (if required) within 30 days of episode opening.

The assessment and authorization process needs to be completed within sixty (60) days of an initial opening for both Adult and Children’s Systems of Care providers, or for an episode where the client was closed for services for over 180 days (6 months) and is being re-opened to services.

Assessment information must be updated on an annual basis for clients under the age of 18 and every (3) three years for clients age 18 and older.
4.2 CLIENT TREATMENT PLANNING

The Client Treatment Plan, co-created by the client/family and the provider, outlines the problems, strengths and means for coping, challenges, natural sources of support, goals, objectives, interventions and timeframes. The Plan must substantiate current and ongoing medical necessity for treatment and services by focusing on diminishing the functional impairment(s) and/or the prevention of deterioration that has been identified through the Assessment process and the Clinical Formulation. The functional impairment(s) and/or deterioration to be addressed must be consistent with the diagnosis which is the focus of treatment. Program objectives should be consistent with the client's/family’s goals as well. Strength-based and recovery oriented treatment planning is strongly encouraged.

Translating Client Goals into specific, observable/measureable objectives requires considerable skill. Usually what is involved is uncovering concrete issues, behaviors, or barriers that are preventing the client/family from accomplishing their goals. Following this is a discussion to frame the issue/barrier in a way that is acceptable to the client/family, but is also meaningful in terms of focusing services. These discussions can all be claimed as Plan Development. An ideal objective is one that meets both the client/family’s needs in working towards the goal, and is specific and measureable enough to be able to chart progress. It is helpful to follow the acronym SMART when formulating goals and objectives: Specific, Measurable, Attainable, Realistic, Time Limited.

1. Key points of Client Client Treatment Plan documentation:

   a. Provides the focus of treatment
   b. Contains the client’s personal life goals, including their hopes and dreams (Writers are encouraged to include client quotes)
   c. Highlights client’s/family’s strengths and resources to achieve their goals
   d. Lists Objective(s) - that which is to be accomplished by the treatment
      - Must be “specific, observable and/or measurable”
      - Must focus on functional impairments which are related to an included diagnosis
   e. Identifies Intervention(s) – how the service provider intends to address the functional impairment, as well as the modality for completing the intervention (Rehabilitation, Case Management, Medication Services) with specificity on what the interventions will be
      - Must include the frequency and duration of the intervention
      - Must be consistent with the client’s goals and listed objectives
   f. Completed prior to the delivery of planned services and within 60 days of the start of service and no less than annually thereafter
   g. Client signature documents their participation in the development of the Client Client Treatment Plan
   h. Clients are offered a copy of the plan and whether they accept or decline is documented
2. Suggested actions when clients are unable to sign electronically:

a. Keep Client Treatment Plan in draft until client is able to come to the clinic to sign in EHR or staff is able to bring a laptop with signature pad
b. Document clearly that all sections are agreed upon via phone discussion with the client
c. Finalize and print the Client Client Treatment Plan for client to sign then file in paper-based chart

The client/family’s participation and understanding of all elements in their plan is essential for successful outcomes and is required by state regulations. The only exception is when a person has a legal status that removes his/her decision making power, e.g., LPS Conservatorship. It is a good practice to routinely review the Client Client Treatment Plan with the client/family/Conservator and with the treatment team throughout the authorization period in order to consistently review Medical Necessity and the appropriateness of services provided.

3. Providing services after the Assessment and prior to completion of the Client Client Treatment Plan

Doing a thorough Assessment and developing the Client Treatment Plan is the initial priority to ensure services are focused on creating goals and objectives to address the medical necessity for services and treatment. Only Assessment, Plan Development, Case Management, and Crisis Intervention procedures may be claimed until the plan is finalized. Intake is the process in which clients are referred and triaged for services.

* can occur at any time between intake and discharge
5.1 DESCRIPTIONS OF MENTAL HEALTH SERVICE PROCEDURES AND MEDICAL BILLING

Specialty Mental Health Services include individual or group therapies and interventions that are designed to reduce mental disability and/or facilitate improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. Services are directed toward achieving the client's/family's goals and must be consistent with the current Client Treatment Plan.

These services include:

- Assessment
- Plan Development
- Rehabilitation
- Therapy
- Collateral
- Targeted Case Management
- Crisis Intervention
- Medication Support

Assessment - 90791

Title 9 §1810.204 – defines Assessment as a service activity designed to evaluate the current status of a beneficiary’s mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history, diagnosis; and the use of testing procedures.

This procedure is used to document the clinical analysis of the history and current status of the individual's mental, emotional, or behavioral condition. It includes appraisal of the individual's functioning in the community such as living situation, daily activities, social support systems, health history and status. Assessment includes screening for substance use/abuse, establishing diagnoses and may include the use of testing procedures. Assessment

Who may bill for Assessment Services?
Licensed Mental Health Practitioner (LMHP)
services must be provided by a licensed and/or licensed waived practitioner consistent with his/her scope of practice.

Assessment services may include:

- Gathering information to gain a complete clinical picture
- Interviewing the client and/or significant support person
- Formulating a diagnosis
- Completing an Initial Clinical Assessment and Annual Clinical Reassessment
- Psychological testing
- Observing the client in a setting such as milieu, school, etc., which may be indicated for clinical purposes
- Conducting a Functional Assessment to inform a behavioral plan

A good Assessment Progress Note includes some observations or findings relating to the Assessment. It is not acceptable to simply write a note indicating an Assessment was completed. The Progress Note needs to include why the Assessment is being completed and preliminary findings or observations of the client’s behaviors during the assessment process.

Assessment notes may contain elements which only licensed/registered or waiveded staff can perform, such as assigning diagnoses, or which require a license or specific training, such as conducting mental status examinations. Staff should only provide and document assessment services within their scope of practice.

Initial and annual assessment progress notes must include documentation that staff reviewed and explained the necessity of the following required materials: Consent to Treatment, Release of Information, Notice of Privacy Practices, Problem Resolution Guide, Advanced Healthcare Directives, Provider List, Medi-Cal Guide to Mental Health Services, and Acknowledgement of Receipt. Note if client is unwilling to sign ROIs, Consent to Treat and/or Acknowledgement of Receipt with reason. Provide evidence that cultural and linguistic needs were discussed and offered.

Plan Development – H0032

*Title 9 §1810.232* – defines Plan Development as a service activity that consists of development of Client Treatment Plans, approval of Client Treatment Plans, and/or monitoring of a beneficiary’s progress.

This procedure is used to document the development of Client Treatment Plans, obtaining client/family approval and signature on the plan and updating or revising the Client Treatment
Plan. Plan Development is expected to be provided during the development of the initial plan and for subsequent Client Treatment Plan updates. However, it may be used during other times than the periodic update cycle, as clinically indicated to modify the plan to make it relevant to client needs. For example, when the client’s status changes (i.e., significant improvement or deterioration), there may be a need to update the Client Treatment Plan.

Plan Development services may include:

- Development and client/family approval of Client Treatment Plans
- Negotiating plan objectives with client or significant support persons
- Verification of medical or service necessity for services listed on Client Treatment Plan
- Evaluation and justification for modifying the Client Treatment Plan
- Updating, revising, renewing Client Treatment Plans
- Development of a behavioral plan connected to the Client Treatment Plan
- Creation of a crisis or safety plan

Client Treatment Plans may be developed by non-licensed clinical staff, who can claim for this procedure. However, Client Treatment Plans must be approved by licensed and/or licensed waivered staff.

Rehabilitation – 97535 (individual), 97535G (group)

*Title 9 §1810.243 – defines Rehabilitation as a service activity which 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.*

This procedure is used to document services that assist the client in improving a skill or the development of a new skill set. “Rehabilitation” means a recovery or resiliency focused service activity identified to address a behavioral health need that is documented in the Client Treatment Plan. This service activity provides assistance in restoring, improving, and/or preserving a client’s functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the client. This procedure may be provided in an individual or group format. This procedure may be claimed by any practitioner.

Who may bill for Plan Development Services?
Licensed Mental Health Practitioner (LMHP)
Mental Health Rehabilitation Specialist (MHRS)*
* Client Treatment Plan requires co-signature from LMHP

Who may bill for Rehabilitation Services?
Licensed Mental Health Practitioner (LMHP)
Mental Health Rehabilitation Specialist (MHRS)
Mental Health Worker (MHW)
Rehabilitative Mental Health Services are provided as part of a comprehensive specialty behavioral health services Unit available to Medicaid (Medi-Cal) clients that meet medical necessity criteria established by the State, based on the client’s need for Rehabilitative Services established by an Assessment and documented in the Client Client Treatment Plan.

Rehabilitation services may include:

- Daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication compliance
- Counseling of the client including psychosocial education aimed at helping achieve the individual’s goals
- Education around medication, such as understanding benefits of medication (within the practitioner’s scope)
- Development and practice of coping strategies to increase client’s efficacy with symptom management

Group Rehabilitation (97535 G)

This procedure is used to document services that assist the client in improving a skill or the development of a new skill set in a group setting. Rehabilitative or skill building groups facilitated by no more than 2 providers. Each staff member’s role must be documented as unique, unduplicated, and necessary.

Specialty Mental Health Services may be provided to more than one (1) individual at the same time. One or more practitioners may provide these services and the total time for intervention and documentation may be claimed. Up to three (3) practitioners may claim the service with a varying amount of time claimed by each practitioner.

Only one group progress note is written for each client even if two (2) or three (3) practitioners lead the group. One practitioner writes and signs/finalizes the Progress Note. A good group note includes specific interventions and specific responses/observations for each client in the group.

Example: A group service is provided by two (2) practitioners for a group of seven (7) clients, and the reimbursable service, including direct service, travel time, and documentation time took 1 hour and 35 minutes (95 minutes). The time reported for each staff will be totaled then divided by the number of clients. Avatar will provide the allocation of time for each client present; rounded to the nearest minute. In this example, each client account will be claimed for 27 minutes. (95 minutes x 2 staff = 190 minutes / 7 clients = 27.1 minutes rounded to 27)

No need to do math if you are documenting in the electronic health record --
Avatar will do it for you!

22
Individual Therapy – 90832, 90834, 90837

*Title 9 §1810.250* – defines Therapy as a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

This procedure is used to document services that assist the client in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors. Therapeutic intervention includes the application of strategies incorporating the principles of development, wellness, adjustment to impairment, recovery and resiliency. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a client or group of beneficiaries and may include family therapy directed at improving the client's functioning and at which the client is present.

Progress notes must adequately document the therapeutic intervention(s) or therapy activity that was provided.

Only licensed/registered/waivered staff, and trainees who have the training and experience necessary to provide therapy, can bill for this procedure.

Therapy is defined as a service activity which is:

- A therapeutic intervention
- Focused primarily on symptom reduction
- Utilized to improve functional impairments
- May also incorporate using play equipment, physical devices, language interpreter or other mechanism of non-verbal communication.

**Individual Therapy services may include:**

- Skill building to work on treatment goals
- Process past trauma, grief, abuse
- Utilization of varied effective modalities (interventions, practices, exercises): Cognitive Behavior Therapy (CBT), Interpersonal Psychotherapy (IPT), Narrative Therapy, Family Therapy and family-based interventions, Parent-Child Interaction Therapy (PCIT), Acceptance and Commitment Therapy (ACT), Solution-Focused Brief Therapy (SFBT), Dialectical Behaviour Therapy (DBT), Schema-Focused Therapy, Psychodynamic Psychotherapy, Emotion-Focused Therapy (EFT), Motivational Interviewing (MI)

Collateral – 90887

*Title 9 §1810.206* – defines Collateral as a service activity to a significant support person in a beneficiary’s life for the purpose of meeting the needs of the beneficiary in
terms of achieving the goals of the beneficiary’s Client Treatment Plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, 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 beneficiary may or may not be present for this service activity.

This procedure is used to document contact with any “Significant Support Person” in the life of the client (e.g., family members, roommates) with the intent of improving or maintaining the mental health of the client, and must be for the purpose of the client not the support person. This generally excludes other professionals involved in the client’s care. Collateral may include helping significant support persons understand and accept the client’s challenges/barriers and involving them in planning and provision of care. Remember, there must be a current release of information in the chart to include these supports, and these services must be included in the client’s Client Treatment Plan to support the client’s recovery. The client may or may not be present for a collateral service.

Collateral services may include:

Consultation and training of the significant support person to assist in better utilization of behavioral health services by the client
- Consultation and training of the significant support person to assist in better understanding of the client’s serious emotional disturbance (e.g., psychoeducation) or serious mental illness
- A list of people involved in the services and their role
- A description of training/counseling provided to the significant support person
- A description of how the client’s behavioral health goals were addressed through collateral support
- Documentation of the collateral support person’s response to the interventions
- A follow-up plan (if needed)

When consulting with other professionals involved with the client’s care, use the Targeted Case Management or Plan Development service type rather than Collateral.

Targeted Case Management (TCM) – T1017

*Title 9 §1810.249* – defines Targeted Case Management as services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; placement services; and plan development.
While included among the Specialty Mental Health services as a core service to clients, Targeted Case Management (TCM) services are not technically categorized as a SMHS under Title 9. TCM, also known as Brokerage, Case Management (CM), or Linkage, refers to services that assist a client to access needed medical, educational, social, pre-vocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure client access to service; monitoring of the client’s progress once he/she receives access to services; and development of the plan for accessing services.

*TCM must be listed as an intervention on the Client Treatment Plan,* as it will be provided to support a client to reach Unit and personal goals. It is an integral function of assisting clients in accessing needed supports and resources. TCM interventions should be directed to functional impairments related to an included Diagnosis and substantiate medical necessity.

**TCM services may include:**

- Inter-and intra-agency communication, coordination, and referral
- Monitoring service delivery to ensure an individual’s access to service and the service delivery system
- Linkage services focused on acquiring transportation, housing, or securing financial needs
- TCM services may also include placement service such as:
  - Locating and securing an appropriate living environment
  - Locating and securing funding
  - Pre-placement visit(s)
  - Negotiation of housing or placement contracts
  - Placement and placement follow-up
  - Accessing services necessary to secure placement

*Institutional reimbursement limitations apply when TCM is billable for clients in acute settings like the hospital (e.g. Woodland Memorial Hospital, 3B North).*

**For clients in these facilities, the following circumstances apply:**

- Use TCM when services are directly related to discharge planning for the purpose of coordinating placement of the client upon discharge
- Use keywords like “Placement” or “Discharge Planning” in the narrative
- For services not related to placement or discharge planning, document services using the “Other Non-Billable” service procedure/code

**Lockouts for TCM Services:**

- When a client is in one of the following locations, no services, including TCM, are claimable to Medi-Cal: IMDs (Institutions for Mental Disease), MHRCs (Mental Health

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**Who may bill for Targeted Case Management?**

*Licensed Mental Health Practitioner (LMHP)*
*Mental Health Rehabilitation Specialist (MHRS)*
*Mental Health Worker (MHW)*
Rehabilitation Centers), Jail and Juvenile Hall, Acute Psychiatric Inpatient, and Psychiatric Health Facilities. TCM may be claimed if the service activity is related to coordinating placement within 30 days of discharge for up to 3 nonconsecutive 30 day periods.

- **Example:** Client is currently at 3BN and will be discharged in 5 days. A provider can utilize non-lockout TCM code if services are geared towards discharge planning.

### Crisis Intervention - 95510

*Title 9 §1810.209* – defines Crisis Intervention as 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. Service activities include, but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contract, site, and staffing requirements described in Sections 1840.338 and 1840.348.

Crisis Intervention is an immediate emergency response that is intended to help a client cope with a crisis (potential danger to self or others, and/or a severe reaction/behavior that is above the client’s normal baseline).

Examples of Crisis Intervention include services to clients experiencing acute psychological distress, acute suicidal ideation, or inability to care for themselves (including provision/utilization of food, clothing and shelter) due to a mental disorder. Service activities may include, but are not limited to Assessment, Collateral and Therapy to address the immediate crisis. Crisis Intervention activities are typically face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community.

### Crisis Assessment Progress Notes Describe:

- The immediate emergency requiring crisis response
- Interventions utilized to stabilize the crisis
- Safety Plan developed
- The client’s response and the outcomes
- Follow-up plan and recommendations

### Examples of Crisis Intervention Activities:

- Client in crisis – assessed mental status and current needs related to immediate crisis
- Danger to self and others – assessed/provided immediate therapeutic responses to stabilize crisis
• Gravely disabled client/current danger to self – provided therapeutic responses to stabilize crisis
• Client is having a severe reaction to current stressors and is an imminent danger to self/others – assessed/provided immediate therapeutic and safety interventions to stabilize crisis

**Must include the following elements** (in order to claim crisis intervention even when the service didn’t result in a 5150 hold):

• Assessment for DTS/DTO/GD
• Statement why or why not the client did or did not meet those thresholds
• Development of a safety plan
• Plan for follow-up care and referrals

*Crisis Intervention progress notes may not always link to the client’s Client Treatment Plan, which is acceptable.*

**Lockouts for Crisis Intervention (§1840.366):**

When a client is in one of the following locations, no services, including Crisis Intervention, are claimable to Medi-Cal: IMDs, MHRCs, Jail, and Juvenile Hall.

Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services. Crisis Intervention is allowed on day of discharge from those facilities.

Limits for Crisis Intervention - The maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours and is based on staff time and is not Unit specific, as described for medication support services.

**Medication Support Services**

This service is used exclusively by medical staff where it is within their scope of practice to provide such services. This service type may include: providing detailed information about how medications work; different types of medications available and why they are used; anticipated outcomes of taking a medication; the importance of continuing to take a medication even if the symptoms improve or disappear (as determined clinically appropriate); how the use of the medication may improve the effectiveness of other services a client is receiving (e.g., group or individual therapy); possible side effects of medications and how to manage them; information about medication interactions or possible complications related to using medications with alcohol or other medications or substances; and the impact of choosing to not take medications. Medication Support Services assist beneficiaries in taking an active role in making choices about their behavioral health care and help them make specific, deliberate, and informed decisions about their treatment options.
Note: Medication support services may only be provided within the scope of practice of the following: Physician/Psychiatrist; Physician Assistant; Nurse Practitioner; Clinical Nurse Specialist; Registered Nurse; Licensed Vocational Nurse; Psychiatric Technician; and Pharmacist. Medical and Nurse Practitioner Students can provide Medication support services as long as they are co-signed by the Medical Director or internal MD supervisor.

Types of Medication Services:

**Medication Assessment:**

- Initial Assessment including medical and psychiatric history, current medication. Observation of need for medication due to acuity. Consultation with clinician, M.D., or nurse regarding medication.

**Medication:**

- Prescribing, administering, and dispensing medication, lab work, vitals, observation for clinical effectiveness, side effects and compliance to medication. Obtaining informed consent for medications.

**Medication Injection:**

- Specifically for the injection and all that an injection entails under guidelines of administration/evaluation of medication.

Limits for Medication Support Services. - The maximum amount claimable for Medication Support Services for a client in a 24-hour period is 4 hours. The limits are client specific and based on staff time, i.e., staff and co-staff providing a 2-hour service to a client would equal four 4 hours. Note that these maximums are based on total staff time, and are not Unit specific. For example, if an MD and an RN are co-staffing a med service that takes two (2) hours, the claimed time is 4 hours. Also if an MD from one Unit is providing a med service in the morning and an RN from another Unit is providing a med service in the afternoon, the time for both count toward the daily maximum.

### 5.2. NON-BILLABLE SERVICES

Some services are not claimable to Medi-Cal. Non-Reimbursable procedures and certain service locations block the service from being claimed. Unclaimable services may include a wide variety of services which may be useful and beneficial to the client, but are not reimbursable as a Specialty Mental Health service. This category of services permits flexibility in Client Treatment Planning and promotes the adoption of recovery-based services to individual clients. Even though these are not claimable, these services should be documented by all staff working with clients.
The following services are not Medi-Cal reimbursable:

1. Any service after the client is deceased. Includes “collateral” services to family members of the deceased
2. Preparing documents for court testimony for the purpose of fulfilling a requirement; whereas when the preparation of documents is directly related and reflects how the intervention impacts the client’s behavioral health treatment and/or progress in treatment, then the service may be billable
3. Completing the reports for mandated reporting such as a CPS or APS. However, any direct services provided that are linked to the report are reimbursable
4. No service provided: Missed visit. Waiting for a “no show” or documenting that a client missed an appointment
5. Services under 5 minutes
6. Traveling to a site when no service is provided due to a “no show”. Leaving a note on the door of a client or leaving a message on an answering machine or with another individual about the missed visit
7. Personal care services provided to individuals including grooming, personal hygiene, assisting with self-administration of medication, and the preparation of meals. However, skill-building activities related to these services are reimbursable
8. Purely clerical activities (faxing, copying, calling to reschedule, appointment, completing any forms when not linked to a direct service, etc.)
9. Recreation or general play
10. Socialization-generalized social activities which do not provide individualized feedback
11. Childcare/babysitting
12. Academic/Educational services, e.g., actually teaching math or reading, etc.
13. Vocational services which have, as a purpose, actual work or work training
14. Multiple Practitioners in Case Conference or meeting: Only practitioners directly contributing (involved) in the client’s care may claim for their services, and each practitioner’s unique contribution to the meeting must be clearly noted
15. Supervision of clinical staff or trainees is not reimbursable because it does not center on client care (i.e. development of personal insight that may be impacting clinician’s work with the client). Whereas, reviewing and amending/updating the Client Treatment Plan with a supervisor is reimbursable (e.g. the topic of discussion is centered on exploring alternative interventions that may be helpful in helping client reach his/her goals)
16. Utilization management, peer review, or other quality improvement activities
17. Interpretation/Translation; however, an intervention in another language may be claimed
18. Providing transportation ONLY
19. NOTE: “Travel” is not “Transportation”
20. Travel involves the provider going from his/her “home office”, to the location where a service will be provided
21. Transportation involves the provider taking the client/family from one location to another
22. If a “behavioral health service” is provided during the time a provider is transporting the client/family, then the time spent providing the service is not “transportation” and that portion of service time can be claimed
Clarification on above items: As long as the focus of the service meets medical necessity criteria, the following include examples of reimbursable services.

1. Academic/Educational Situations:
   a. **Reimbursable**: Providing support to client while in a community college class to help reduce the client’s anxiety and then debriefing the experience afterward
   b. **Not Reimbursable**: Assisting the client with his/her homework
   c. **Not Reimbursable**: Teaching a typing class at an adult residential treatment Unit

2. Recreational Situations:
   a. **Reimbursable**: Helping client to acclimate to a Wellness Center and debriefing his/her visits
   b. **Not Reimbursable**: Teaching the client how to lift weights is not reimbursable

3. Vocational Situations:
   a. **Reimbursable**: Responding to the employer’s call for assistance when the client is in tears at work because he/she is having trouble learning to use a new cash register— if the focus of the intervention is assisting the client to decrease his/her anxiety enough to concentrate on the task of learning the new skill
   b. **Not Reimbursable**: Visiting the client’s job site to teach him/her how to use a cash register

4. Travel/Transportation Situations:
   a. **Reimbursable**: Driving to a client’s home to provide a service – travel time is added to the service time if the client is there and the service is provided
   b. **Reimbursable**: Providing supportive interaction with a client while accompanying the client from one place to another in a vehicle. Claimable time is limited to time spent interacting and must be specific to interventions identified in the Client Client Treatment Plan
   c. **Not Reimbursable**: Taking a client from one place to another during which no interaction takes place
5.3. LOCKOUTS

1. IMDs, MHRCs, Jail and Juvenile Hall
   a. All Medi-Cal Claimable services are locked out. Use only non-billable codes.
   b. Examples of IMD/MHRC facilities include: Crestwoods; California Psychiatric Transitions (CPT), Monroe Detention Facility, etc. (Must clarify with administrator or charge nurse that client is on STP/IMD not SNF bed when placed in an IMD.)

2. Medical Skilled Nursing Facilities (SNF)
   a. Medi-Cal claimable mental health services are not locked out. Examples of SNFs include: Alderson’s Skilled Nursing Facility, Woodland Skilled Nursing Facility, etc.
   b. Note that an IMD may be classified as a SNF, but is a lockout in terms of Medi-Cal claimable services

3. Acute Psychiatric Inpatient
   a. Examples of acute psychiatric inpatient include: Woodland Memorial Hospital, 3B North; Heritage Oaks Hospital; Sierra Vista Hospital; Sutter Center for Psychiatry

4. Psychiatric Health Facility (PHF)
   a. May use TTCM if service activity relates to placement within 30 days of discharge, and occurs in no more than 3 non-consecutive 30 day periods
      • If other services, including medication services, are provided while client is hospitalized in a Short-Doyle Medi-Cal hospital, use lockout non-claiming procedure/location for any date of service other than on day of admission
      • Fee-for-Service hospitals may claim other services during hospitalization
      • Other services provided on day of admission, which occurred before the actual admission are allowed
      • All services are allowed on day of discharge

5. Crisis Residential
   a. TCM and Medication services only allowed. Medication services are allowed if within scope of practice. Mental Health Services, i.e., Individual, Group, Rehab, Collateral, Crisis Intervention are not allowed. May use non-billable codes
      Example of crisis residential: Safe Harbor Crisis House

6. Crisis Intervention
   a. Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services

7. Other residential treatment
   a. For a Medi-Cal certified Adult Residential Facility (e.g., the Farmhouse), Mental Health Services (assessment, plan development, collateral, individual and group therapy, individual and group rehabilitation)
   b. TBS are locked out during the time in which the ARF’s services are billed

8. Other Acute Inpatient
   a. Medical (non-psychiatric) Inpatient services do not have a Medi-Cal lockout
Chapter 6. SCOPE OF PRACTICE/COMPETENCE/WORK

6.1. SCOPE OF PRACTICE/COMPETENCE/WORK

Staff must only provide services that are within their scope of practice, competency and work.

- Scope of practice refers to how the law defines what members of a licensed profession may do in their licensed practice (It applies to the profession as a whole)
- Scope of competence refers to those practices for which an individual member of the profession has been adequately trained
- Scope of work refers to limitations imposed by HHSA to ensure optimal utilization of staff resources

Some services are provided under the direction of another licensed practitioner, including a Physician, a Psychologist, a Waivered Psychologist, a Licensed Clinical Social Worker, a Registered Associate Clinical Social Worker, a Licensed Marriage and Family Therapist, a Registered Marriage and Family Therapist Intern, a Licensed Professional Clinical Counselor, a Registered Professional Clinical Counselor, or a Registered Nurse (including a Certified Nurse Specialist, or a Nurse Practitioner).

- "Under the direction of" means that the individual directing the service is acting as a Unit Supervisor or Manager, providing direct or functional supervision of service delivery, or review, approval and signing of Client Client Treatment Plans
- An individual directing a service is not required to be physically present at the service site to exercise direction
- The licensed professional directing a service assumes ultimate responsibility for the Rehabilitative Mental Health Service provided

"Waivered Professional‘ is defined as: A psychologist candidate, an individual employed or under contract to provide services as a psychologist who is gaining the experience required for licensure and who has been granted a professional licensing waiver to the extent authorized under State law; or

Prior to providing services, “waivered” clinicians must provide the following to the Yolo County Quality Management Unit (137 N. Cottonwood, Suite 2500, Woodland CA 95695):

- State Waiver Form
- School Transcript
- Resume
Waiver packet will be reviewed and sent to the State Compliance for processing. Waiver is good for six (6) years.

“Registered” Professional (MFTi, ASW, PCCI) is defined as: A marriage and family therapist candidate, a licensed clinical social worker candidate, or a professional clinical counselor candidate who has registered with the corresponding state licensing authority for marriage and family therapists, clinical social workers or professional clinical counselors to obtain supervised clinical hours for marriage and family therapist or clinical social worker or professional clinical counselor licensure, to the extent authorized under state law.

Prior to providing services, “registered” clinicians must provide the following to the Yolo County Quality Management Unit (137 N. Cottonwood, Suite 2500, Woodland CA 95695):

- Copy of Certificate Board Issued Intern Registration

6.2 HHSA PROFESSIONAL CLASSIFICATIONS AND LICENSES

Below are tables containing the most common licenses or professional classifications in the Behavioral Health field, with brief definitions and characteristics. In conjunction with information and tables from the preceding sections, these tables can be used to help further clarify what clinical activities are within the scope of practice of particular professionals.

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<tbody>
<tr>
<td><strong>Title</strong></td>
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<tr>
<td>MHRS (Mental Health Rehabilitation Specialist)</td>
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<td>ASW (Associate Social Worker)</td>
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<td>MFTI (Marriage and Family Therapy Intern)</td>
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<td>LPCCI (Licensed Professional Clinical Counselor Intern)</td>
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<thead>
<tr>
<th>Title</th>
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<td>Psychologist (Licensed)</td>
<td>Licensed by the CA Board of Psychology Possesses a current CA Board of Psychology license certificate (which contains a valid license number)</td>
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<tr>
<td>Psychologist (Waivered)</td>
<td>Issued a waiver by the State of CA Department of Health Care Services to practice psychology in CA. Possess valid waiver. Waiver is limited to 5 years.</td>
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<td>LCSW (Licensed Clinical Social Worker)</td>
<td>Licensed by the CA Board of Behavioral Sciences (BBS) Possesses a current BBS license certificate (which contains a valid BBS license number)</td>
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<td>MFT (Licensed Marriage and Family Therapist)</td>
<td>Licensed by the CA Board of Behavioral Sciences (BBS) Possesses a current BBS license certificate (which contains a valid BBS license number)</td>
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Scope of Practice is defined by Title 9, CCR, Section 1810.227 and further clarified by DMH Letter No. 02-09. The grid above provides an outline but does not authorize individual practitioners to work outside their own scope of competence.

Some staffing classifications require a co-signature where the clinical supervisor provides clinical supervision using the co-signature as a supervision tool. State laws and regulations specify that a co-signature does not enable someone to provide services beyond his/her scope of practice.

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<td>Complete Client Treatment Plan</td>
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<tr>
<td>Crisis Intervention</td>
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<tr>
<td>Medication Administration</td>
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<tr>
<td>Medication Dispensing</td>
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<tr>
<td>Medication Prescribing or Furnishing</td>
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<td>Med support svc.</td>
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<td>Psychological Testing</td>
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<td>Psychotherapy</td>
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<td>Rehabilitation Counseling</td>
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<tr>
<td>Targeted Case Management</td>
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<tr>
<td>Therapeutic Behavioral Services</td>
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<td>Collateral</td>
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<tr>
<td>Plan Development</td>
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<tr>
<td>KTA ICC</td>
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<tr>
<td>KTA IHBS</td>
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</table>

* Co Signature Required
^ Staff w/ specific training and experience may qualify, upon approval of the MH Director
* RN’s may dispense if trained in dispensing and re-certified annually;** LVNs/Psych Techs may not administer IV medications
  ++ Must have immediate supervision if issues of danger to self or others are present
APPENDIX A: Progress Notes/Documentation Standards Policy and Procedure

137 N. Cottonwood Street, Suite 2500
Woodland, CA 95695
Policy No. 210
Effective Date: 05/14/2004
Last Revision: 1/1/2014

YOLO COUNTY DEPARTMENT OF HEALTH SERVICES
ALCOHOL, DRUG AND MENTAL HEALTH
POLICY AND PROCEDURES MANUAL
SUBJECT: Progress Notes / Documentation Standards

POLICY

It shall be the policy of ADMH to document any and all service activities/encounters provided to Medi-Cal beneficiaries, Medicare/Medicare Risk HMO beneficiaries, and all other Non-Medi-Cal/Medicare clients regardless of funding/payer source in AVATAR CWS using the templates outlined in the Yolo County Clinical Documentation guide, which is based on state and federal requirements. Pursuant to the provisions of the Mental Health Plan (MHP) contract with the California Department of Health Care Services (DHCS) and, applicable State and federal law and regulation (REFERENCES), progress notes shall document service activities and encounters in the client record at the frequency and timeliness by type of service indicated below:

A. Every Service Contact for
   1. Mental Health Services
   2. Medication Support Services
   3. Crisis Intervention
   4. Targeted Case Management

B. Daily for
   1. Crisis Residential
   2. Crisis Stabilization (1 X 23-Hrs.)
   3. Day Treatment Intensive

C. Weekly for
1. Day Treatment Intensive:
2. Day Rehabilitation: Same
3. Adult Residential: Same

D. Psychiatric Health Facility (PHF), each shift

DEFINITIONS

A. Specialty Mental Health: Specialty Mental Health Services are those provided to Seriously Mentally Ill adults and Seriously Emotionally Disturbed children/youth. The interventions are designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning to achieve independent living and enhance self-sufficiency. When providing to seriously emotionally disturbed children and adolescents, Specialty Mental Health Services provide a range of services to assist the child/adolescent in gaining the social and functional skills necessary for appropriate developmental and social integration.

B. Practitioner: Any staff that provides direct services, including Mental Health Service, Targeted Case Management, Medication Support, and Crisis Intervention.

PROCEDURES

A. General Requirements: Medi-Cal documentation standards shall prevail except where these are preempted by alternate and more restrictive documentation practices established by ADMH, Medicare or other payers/funding sources. To ensure that quality of care standards and MHP contract provisions are met, the specific timelines established for clinical documentation/progress notes in AVATAR CWS shall be as follows:

1. Progress Notes shall be entered into AVATAR CWS on the same date of the encounter/service activity or within five (5) business days following the date of service or encounter.

2. Progress Notes entered into AVATAR after five (5) business days following the date of service/encounter through thirty (30) days shall be considered a Late Entry and must be reviewed and approved by a supervisor or designee.

3. Progress Notes entered after 30 calendar days following the date of service/encounter shall not be claimed to Medi-Cal/Medicare for reimbursement.

4. Except as allowed by regulation and/or statute; no Progress Note/Service shall be claimed for reimbursement unless there is evidence of a current client plan, current assessment, and medical necessity criteria are established. Staff/Providers that render the service and write the progress note are responsible for ensuring that these said requirements have been satisfied.

5. In the event that any practitioner becomes aware of an inappropriate/inaccurate billing practice, they must inform their immediate supervisor, manager and/or Deputy Director. The supervisor shall take immediate action to ensure that the inappropriate practice does not reoccur and document their efforts to provide the necessary supervision to the clinician and/or staff member.

B. Medi-Cal Requirements: In addition to the General Requirement above, the following requirements shall apply for claiming Medi-Cal covered services based on minutes of time:
1. The exact number of minutes used by practitioners providing a reimbursable service, including applicable documentation and travel time, shall be reported and billed with relevant and timely progress note documentation. In no case shall a practitioner bill for more hours/minutes than were worked in a day. For example, a practitioner cannot bill for ten (10) hours in a day if they only worked eight (8).

When a practitioner provides service to or on behalf of more than one beneficiary at the same time, the practitioner’s time must be prorated to each beneficiary. When more than one practitioner provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.

2. Only Specialty Mental Health Services that comply with the established Medical Necessity criteria within the ‘scope of practice’ of the rendering staff/provider shall be reported or claimed for reimbursement.

3. The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity.

4. Plan development for Mental Health Services and Medication Support Services is reimbursable. Units of time may be billed regardless of whether there is a face-to-face or phone contact with the beneficiary.

C. Medicare Requirements: In addition to the General Requirements described above in paragraph “A”, Medicare documentation shall include the following elements:

1. At a minimum and for a medical/physician service, any three of the following seven vital signs:
   a. Sitting or standing blood pressure,
   b. Supine blood pressure,
   c. Pulse rate and regularity,
   d. Respiration,
   e. Temperature,
   f. Height,
   g. Weight (May be measured/document by ancillary staff).

2. The most current version of American Medical Association - Current Procedural Terminology (AMA/CPT) codes specifying the amount of time and identifying whether the client is a new or existing client must be utilized.

3. Documentation of each patient/client encounter which includes:
   a. Reasons for the encounter and relevant history, physical examination findings, and prior diagnostic test results;
   b. Assessment, clinical impression, or diagnosis;
   c. Medical plan of care;
   d. Prescription/Over-the-Counter Medications and Supplements; and,
   e. Date and legible identity/signature of provider.
4. The rationale for ordering diagnostic and other ancillary services should be easily inferred from the progress note.

5. Appropriate health risk factors should be identified and noted prominently.

6. The client’s progress, response to and changes in treatment, and revision of diagnosis should be documented.

**Additional Requirements:** More stringent or additional documentation requirements may be implemented for certain programs to meet conditions imposed by state and federal regulatory entities or by other insurers. Grant funded programs may require the submission of other documentation to meet contract and/or grant requirements.

**REFERENCES:**
- CCR, Title 9, Chapter 11, Section 1810.440(c)
- CCR, Title 9, Chapter 11, Section 1840.314
- CCR, Title 9, Chapter 11, Sections 1840.316 – 1840.322
- CCR, Title 22, Chapter 3, Section 51458.1
- CCR, Title 22, Chapter 3, Section 51470
- MHP Contract, FY2012/13 through FY2015/16 between State Department of Health Care Services and County of Yolo, Contract No., Exhibit A – Attachment 1 – Appendix C
- Evaluation and Management Services Guide: Department of Health and Human Services, Centers for Medicare & Medicare Services (December 2010 / ICN: 006764)

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**APPROVED BY:**

__________________________  _______________________
Mental Health Director/Alcohol & Drug Administrator  Date
### APPENDIX B: MHP Standardized Abbreviations

**Yolo County Health and Human Services – MHP Standardized Abbreviations**

*Revised May 2, 2016*

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYMBOLS</td>
<td>SHORTCUT KEYS</td>
</tr>
<tr>
<td>1:1</td>
<td>one to one (Alt+058)1</td>
</tr>
<tr>
<td>5150</td>
<td>WIC 72 hour hold for mental health evaluation</td>
</tr>
<tr>
<td>5250</td>
<td>WIC 14 day hold</td>
</tr>
<tr>
<td>-</td>
<td>Minus, negative, no Alt+0150</td>
</tr>
<tr>
<td>α</td>
<td>Before Insert&gt;Symbol&gt;Unicode(hex)&gt;Character Code:1FB1</td>
</tr>
<tr>
<td>#</td>
<td>Number Alt+35</td>
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<td>Percent Alt+37</td>
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<td>&amp;</td>
<td>And Alt+38</td>
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<tr>
<td>?</td>
<td>Unknown Alt+63</td>
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<tr>
<td>@</td>
<td>At Alt+64</td>
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<tr>
<td>’</td>
<td>Feet Alt+39</td>
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<tr>
<td>“</td>
<td>Inches Alt+34</td>
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<tr>
<td>+</td>
<td>Plus, positive, yes Alt+43</td>
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<tr>
<td>=</td>
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<td>Decrease Alt+25</td>
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<td>♂</td>
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<tr>
<td>✝</td>
<td>Male Alt+11</td>
</tr>
<tr>
<td>1°</td>
<td>Primary 1 (Alt+0176)</td>
</tr>
<tr>
<td>2°</td>
<td>Due to; Secondary to 2 (Alt+0176)</td>
</tr>
<tr>
<td>24/7</td>
<td>24 Hours A Day/Seven Days A Week 24(Alt+047)7</td>
</tr>
<tr>
<td>3BN</td>
<td>Woodland Memorial Hospital Psychiatric Inpatient Unit</td>
</tr>
<tr>
<td>5 HT</td>
<td>Serotonin</td>
</tr>
<tr>
<td>5HT2</td>
<td>Serotonin 2 Receptor</td>
</tr>
<tr>
<td>Ψ</td>
<td>Psychiatric/Psychiatrist/Psychology Insert&gt;Symbol&gt;Unicode(hex)&gt;Character Code:03A8</td>
</tr>
<tr>
<td>A</td>
<td>Auditory Hallucinations</td>
</tr>
<tr>
<td>A/H</td>
<td>Alert &amp; Oriented</td>
</tr>
<tr>
<td>A/O</td>
<td>Adult/Older Adult Services</td>
</tr>
<tr>
<td>A/OA</td>
<td>Assessment / Plan</td>
</tr>
<tr>
<td>AA</td>
<td>Alcoholics Anonymous</td>
</tr>
<tr>
<td>ac</td>
<td>Before Meals</td>
</tr>
<tr>
<td>ACT</td>
<td>Assertive Community Treatment Team</td>
</tr>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act</td>
</tr>
<tr>
<td>ADD</td>
<td>Attention Deficit Disorder</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>ADM</td>
<td>Admission</td>
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<tr>
<td>ADMH</td>
<td>Alcohol, Drug and Mental Health</td>
</tr>
<tr>
<td>ADMIN</td>
<td>Administrative</td>
</tr>
<tr>
<td>ADOL</td>
<td>Adolescent</td>
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<tr>
<td>ADP</td>
<td>California State Office of Alcohol and Drug Programs</td>
</tr>
<tr>
<td>ADV DIR</td>
<td>Advance Directive</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AKA</td>
<td>Also Known As</td>
</tr>
<tr>
<td>ALOC</td>
<td>Altered Level Of Consciousness</td>
</tr>
<tr>
<td>am</td>
<td>Morning</td>
</tr>
<tr>
<td>AMA</td>
<td>Against Medical Advice or American Medical Association</td>
</tr>
<tr>
<td>AMPHET</td>
<td>Amphetamines</td>
</tr>
<tr>
<td>AMS</td>
<td>Acute Mental Status (on emergency room records) or Altered Mental Status</td>
</tr>
</tbody>
</table>
MISSING OTHER PAGES OF ABBREVIATIONS

APPENDIX C: Note Samples

**Targeted Case Management - T10107**

- *Exchange of information directly related to client’s case that will inform plan making, treatment planning, interventions, meeting mental health needs, and/or linking clients to needed services*
- *Linking client to services/resources in the community that helps them get their needs met as related to mental health.*

1.

B – Adult consumer was brought into the clinic for an appointment. During the appointment, the consumer and her sister reported that the consumer has been meeting with her medical doctor for issues not related to her mental health treatment.

I – Discussed the value of communicating with consumer’s primary care physician in order to coordinate care and rule out medical conditions that may affect mental health symptoms or treatment. Further explained the importance of obtaining client’s medical records for the psychiatrist to review to determine whether psych meds are appropriate and safe in conjunction with other medications the consumer’s primary care physician is currently prescribing.

R- Consumer agreed to have coordination of care by mental health and medical care providers. Consumer signed a release to allow verbal exchange of information with her doctor, as well as permission for her doctor to send client’s medical records. The consumer accepted the offer to have a copy of the release for her records.

P – Writer to follow up with a letter to the consumer’s medical provider requesting consultation and coordination of services, and to submit the release for medical records.

2.

**INDIVIDUALS INVOLVED:** John (client), Safe Harbor Staff and Beth (MHRS Specialist).

**PURPOSE STATEMENT:** Writer traveled from Woodland office to Safe Harbor to provide Targeted Case Management Services to discuss discharge plan. John is on target to transition to independent housing in a week as his symptoms are improving.

**HOW SERVICES SUPPORT CLIENTS TREATMENT GOALS:** In order for client to successfully transition to independent living he needs to be engaged in an outpatient substance abuse program. Writer assisted client with scheduling pre-treatment appointment at John H. Jones in order for him to meet his scheduled discharge date and successfully maintain independence.

**INFORMATION GATHERED:** Writer consulted with Safe Harbor staff regarding the plan to refer John to John H. Jones. They were supportive and felt that it was necessary in order to ensure the best outcome. Staff at Safe Harbor provided an update on his progress, he is
medication compliant, showing improved symptom management and is on target for discharge in a week.

INFORMATION PROVIDED: Writer informed Safe Harbor staff of plan for pre-screening appointment. John presented as calmer, less pressured speech and more focused during conversation.

PLAN: John will remain at Safe Harbor for another week and continue to meet with psychiatrist. Writer will assist John to his pre-treatment appointment.

3.

Writer (MHRS Specialist) met with John (client) in the Woodland office for the purpose of providing case management services to ensure stable housing as it will support improved mental health. Client provided writer with a letter he received from the housing authority. He stated that he was confused about what the letter meant and did not know what to do. He express feeling stressed because he does not want to lose his housing. Writer assisted John with contacting the housing authority to get information regarding his letter. Writer was informed that he was due for a housing inspection and needed to contact them to schedule a date before the end of this month. John was able to schedule the inspection and get additional information on how to prepare for the inspection. Writer praised and reinforced John for his efforts to address this. PLAN: Writer will continue to support John with maintaining stable housing.

Rehabilitation - 97535

• Skills training with interventions to address symptoms, behaviors, and functional impairments related to primary diagnosis and to address mental health goals stated in the treatment plan.

1.

INDIVIDUALS INVOLVED: Sally (client) and Writer (mental health specialist)

PURPOSE STATEMENT: Met with Sally in the Woodland office for the purpose of providing rehabilitation services. Worked with client on her goal to improve expressing intense feeling and regulate emotions in a healthy way in order to improve interactions with others.

BEHAVIORS: Client reports increased feeling of depression, anger and feeling drained after receiving news that her boyfriend was given a longer sentence than she expected. She stated, "I feel like I just want to run away."

INTERVENTIONS: Provided active and supportive listening to encourage Sally to express her frustration. Assisted her with identifying and labeling current emotions as she tends to avoid or suppress her uncomfortable emotions which result in negative interactions with others. Reviewed her stress management skills and encouraged her to utilize them. Sally reported that
being able to verbalize how she feels left her feeling supported and more calm. She plans to
use journaling while she is at home as a way to express her feelings and she will also go for
walks as a way to manage stress.

STRENGTHS: Motivated to feel better, resourceful and able to make her appointments
consistently.

PLAN: Continue to support client with labeling feelings and utilizing stress management skills.
Writer will discuss specific groups that Sally could attend in the Wellness Center to reinforce
positive interactions with others.

2.

This writer (MHRS) traveled from the Woodland office to the Davis office for the purpose of
providing rehabilitation services. This writer worked with John (client) on his goal of decreasing
delusions and hallucinations. John shared that the messages from the television have
increased and are stressing him out and keeping him awake at night. Writer facilitated a
discussion with John around his current stressors at home as stress tends to intensify his
symptoms. Reviewed some relaxations techniques and coping skills he can utilize to decrease
stress. John did share that he has been feeling lonely since his neighbor who was a significant
support person moved out. Writer provided support and validated his feelings. Encouraged him
to increase his involvement in things he enjoys (walking, reading books and listening to music).
Writer discussed and offered for client to attend groups in the Wellness Center where he can
establish healthy relationships with others and decrease his isolation, he agreed. John was
provided praise for maintaining his independently living, for his sense of humor and he friendly
attitude, and for attending all his appointments. Writer will continue to work with John on
decreasing delusions and hallucinations in order to prevent homelessness and psychiatric
hospitalizations.

3.

B- Traveled to client’s home in Davis to meet with client, 40 minutes round trip travel. Client
was distracted as he appeared to be responding to internal stimuli. He avoided eye contact and
muttered to himself occasionally. Client meets medical necessity due to symptoms of internal
preoccupation, paranoia, auditory hallucinations that impact the client’s daily functioning in the
home and in the community.

I – Provider assisted the client to identify methods to learn the bus system so that he could
attend community college. Continued to assist client to practice coping with internal stimuli and
interacting with others in a socially appropriate manner. Focus of activity was to role-play eye
contact, and teach basic reciprocal communication skills required for education participation
goal on his service plan.

R – Client was able to sustain more eye contact. He was able to verbalize that his voices were
telling him not to look at this writer, but he knew that this writer was trying to help him so he
could keep going to school. He was able to read the bus schedule and identify what time he
should be at the bus stop in order to be on time for class.
P- Follow-up appointment set in one week to build upon current skills. Plan to role play with client on how to advocate for self with school staff.

**Katie A Intensive Care Coordination (ICC) - KTAT1017**

Location of Service: Client’s Home

Goal: John will increase replacement behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder to reduce client’s kicking and punching siblings and peers from 5x per day to 1x per week.

John reported no angry outbursts at school for the last 5 days. Has been playing basketball with peers after school. John also shared that he was invited to a classmate’s birthday party on Saturday and is looking forward to going to the party.

John’s mother and grandmother reported his progress in self-regulation at home and school. With encouragement and prompting from maternal grandmother, John is able to complete his homework and has been taking care of his hygiene. He has been taking his prescribed medications without resistance from mother. Mother is pleased with client’s behavioral improvement.

Parent Partner informed team that Mrs. S. continues to participate in school conferences and IEP meetings, which has helped mother better understand the context of John’s behavior. Parent Partner also reported fewer altercations between client and mother because of improved communication styles between the two. ICC Coordinator led discussion regarding potential of IHBS worker decreasing amount of sessions at the home but continuing to reinforce anger management plan. John smiled at the idea of the IHBS worker coming less. When the ICC Coordinator prompted John to share why he was smiling, client stated “it makes me feel like I am getting better.” Mother was supportive of the idea but asked if the IHBS worker could still come every week. The IHBS worker shared that she thought working on other ways to express feelings might be helpful to the John and his family. Parent Partner acknowledged mother’s appropriate communication skills, discussed with mother importance of consistency in dealing with John’s outbursts. Parent Partner will assist mother in developing a plan to support and recognize appropriate behavior and social interaction. IHBS worker will meet with John, reinforce his anger management plan and teach alternative ways in expressing feelings.

Mrs. S. reported feeling much more confident in her own response when John is struggling and that she understands the importance of her response to John in helping him to stay calm.

**Katie A Intensive Home Based Services (IHBS) - KTAH2015**

Location of Service: Client’s Home
Goal: John will reduce aggressive behaviors related to his diagnosis of Attention Deficit Hyperactivity Disorder, including kicking and punching siblings, from 5x per day to 1x per week and will increase use of pro-social replacement behaviors.

IHBS worker met with mother and aunt to identify situations and triggers at home that contribute to client’s angry outbursts. Family reported that client has been throwing tantrums: kicking and punching his siblings; when they start playing and teasing each other it escalated and got out of hand.

IHBS worker assessed home situation and assisted mother in identifying situations that lead to John’s angry outbursts. IHBS worker and family discussed alternative ways to deal with John’s frustration such as talking to client in a firm but calm tone of voice, and suggesting alternative options. IHBS worker also assisted mother in gaining a better understanding of client’s behavior and need to recognize the behavior she wants to see at least once every 5 minutes from both boys, so that they know what they should do. Also, John agreed that he will take a short client time out when becoming angry. If he becomes violent towards self/family members, he will go to his room for a 15 minute period to calm himself. IHBS worker will continue to assist mother in identifying when the interaction is likely to become out of control so that she can intervene early as well as modeling appropriate responses to client’s outbursts.

Crisis Intervention - 90839

1.

Client was seen at Woodland Memorial Emergency Department, and appeared disheveled, confused, and responding to internal stimuli. Client was brought to the Woodland Clinic by his brother, who reported he found client sleeping in a pile of garbage in client’s living room. Brother reports that he usually checks on client daily by phone, but had not heard from client in two days, and went to check on him. Brother was able to successfully transport client to WMH where client was medically cleared then evaluated by crisis staff and placed in a 5150 hold as gravely disabled. Client was unable to successfully complete most elements of a MSE, and could not answer questions regarding his safety, the safety of others, or the ability to care for himself. Client has a hx of Schizophrenia, and it was noted in client’s chart that there has been a recent change in medication.

Client was medically cleared. Completed crisis assessment to determine Danger to Self, Danger to Others, or level of grave disability. Client was determined to be gravely disabled, and a 5150 was completed on client. Client was placed on a 5150 hold. Client did not show any indication or response that he understood what was going on.

Will contact HHSA on-call psychiatrist to review case and ask for approval to place client at an acute inpatient psychiatric facility. Will contact hospitals to determine placement for client and will contact the police for transport.
2.

P – Received a telephone call from school principal requesting immediate response due to client “throwing a chair at her teacher” and destroying school property at school. This writer arrived at the school site to find client in a quiet room yelling obscenities, threatening to kill her peers if she got out. Upon seeing this writer, client angrily yelled and cursed at me accusing her peers of “setting her up.”

I – Client calmed down after about 15 minutes and agreed to speak with this writer about the incident. Assessed client for risk to herself and to others.

R – After calming down, client was assessed to be at low risk for hurting herself or others. Client was willing to discuss the incident, and reported that she was outside playing with her peers when she was told to “hide” and they would come get her when recess was over. Her peers did not follow through resulting in her teacher advising client that she will receive a demerit for being late to class. At this point, client admitted accusing the teacher of being “unfair” and throwing a chair at him.

P – Was informed that mother had been called and that client would be going home today. Client has been suspended for 2 days for this incident. Will plan to continue to work with client on better anger management techniques and impulsivity control.

Note: While Crisis Staff only respond to the Emergency Departments and the jail, other clinic staff who might be assigned to a school-based site or field location could respond at a location where the client is seen, and bill crisis. All non-“crisis” staff are to use this code only when assessing a client’s risk of Danger to Self, Danger to Others, or Grave Disability. It is not necessary to bill this code only under the Crisis Site Code. In addition, for those staff who primarily work crisis, it may not always be necessary to bill Crisis Intervention, and the appropriate code for the service provided should be used.

Group Rehabilitation - 97535G

Direct (Face-to-Face) Time: 21 min. (95 min. x 2 staff = 190 min. / 9 clients = 21.1 min.)

Documentation Time: 7 min.

Person(s) involved, place, and presenting problem – MHW met with the clients in The Wellness Center for a Socialization Group to help build the client’s social skills. This client was referred to the group to help with building confidence in social situations. The client’s depressive symptoms (low energy, isolation, and avoidance of activities that once brought him joy) have led to the client being fired from his job, staying in his home and sleeping 10-15 hours a day, and decrease in daily hygiene routines. The client presented in old, worn-out jeans, a T-shirt with holes, and a malodorous smell. Client appeared withdrawn and kept his gaze downward.
**Service provided** – The goal of today’s group was to build upon the clients’ social skills development and provide an opportunity to practice these skills with an interactive game of Charades. The clients were encouraged to split into teams of three and come up with a team nickname. The clients were coached on the rules of the game and were provided positive reinforcement for their participation.

**Client’s involvement** – The client was very hesitant to interact with the other group members and sat on the couch while the teams were determined. The client remained quiet while it was his team’s turn. With the encouragement of the group members the client eventually participated and took his turn performing. The client sat quietly for most of the game but his affect changed to a more positive showing as the game progressed. The client appeared to enjoy when the other group members encouraged him to perform.

**Follow-up plan** – MHW plans to contact the client tomorrow to check in to see what the client thought about the group and encourage the client to participate in more of the Wellness Center activities. The client agreed to return to the weekly Socialization group next week and continue working on his socialization skills. The client’s hygiene activities will be brought up in the next individual session.

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**Plan Development – H0032**

- *Working with client and supports on goal and plan creation that is informed by completed assessment.*

1.

P- Reviewed client’s progress on goals and information gathered from school and social worker prior to meeting with foster parents. Met with foster parents in Woodland clinic to discuss future plans for client’s treatment. Client continues to show severe oppositional behaviors in the home, such as hitting peers, stealing money and jewelry from the foster parents, refusal to follow directions, and breaking objects in the home.

I - Discussed the behaviors and the various interventions that have been previously attempted in the home, such as behavior charts, token system, and time outs. Discussed the possibility of TBS services, as client appears to not be benefiting from 1x a week services and possibly needs more intensive services.

R- Foster parents expressed concern over having TBS come into the home, due to the frequency of services, however agreed that there was a need for more intensive services to deal with these behaviors. Foster mother indicated that they have talked about giving notice on the client, but realize that the client has had several placements this year, and she is concerned that giving notice would cause the client harm. After discussing concerns, the foster parents agreed to try TBS.
P: Will plan to complete a referral for TBS services for client to continue with more intensive behavioral services. In the interim, this writer will plan to schedule an additional session with client to include foster parents per week to address the behaviors of hitting and stealing.

2.

Clinician met with client in West Sacramento clinic to formulate the Client Plan that was specific, medically necessary, measurable, observable, specified frequency and duration, and identified client strengths. Client identified frequent hospitalizations and maintaining sobriety as important issues. Clinician and client were able to concur on the following as a focus of the treatment plan: reducing the number of hospitalizations, maintaining sobriety and finding a healthier support system. Goals that were identified and agreed upon by the client were identifying and increasing the use of appropriate coping skills and processing feelings of anger, sadness and frustration through constructive means in session. Client appeared pleased with the goals decided upon. Client expressed that he could honestly commit to maintaining medication compliance and sobriety with support from community, family and this agency. Client signed completed treatment plan. This clinician will be following this client to assist in achieving the above named goals; referrals have been made to AA. Will work closely with psychiatrist in monitoring medication compliance in order to reduce hospitalizations. Client will attend area churches to find a healthy supportive network.

3.

**Purpose:** Met with Client and mother in home, in West Sacramento to complete treatment plan to address the behaviors of not getting along with siblings, fighting in school, and not complying with rules both at home and at school.

**Intervention and Response:** Discussed and formulated treatment plan goals that included reducing argumentative behaviors in home and in school from 7x a day to 3x per week and increasing appropriate expression of feelings (e.g., using “I” statements, using feeling words) from 0x a day to 3x a day. Client participated some in developing the client plan, however continually asked why he had to participate in services. Mother was the primary participant in development of the treatment plan. Client verbally agreed to the client plan once it was complete.

**Plan:** Will review client plan with mother and client for agreement and obtain signatures at the next scheduled appointment. Will plan to review case with supervisor.

**Assessment - 90791**

- *Gathering information through interview and observation for the purpose of informing plan and goal development.*

Initial Assessment Progress Note:

Presenting Problem/Place: The client is a 45yo male who came into the Woodland clinic for a mental health intake assessment following a brief hospitalization for DTS at Woodland
Memorial Hospital. His reported symptoms include delusional thoughts, auditory hallucinations, increased paranoia, difficulty with sleep, and isolative behaviors. The client reported he recently lost his home due to lack of financial support, is unable to keep a job for any significant amount of time, and has very limited family support in this area.

Intervention: The psychosocial assessment is the intervention. In addition, the following information was reviewed, explained, and signed: Informing Materials, HIPAA, Privacy Practices, Confidentiality and the Limits of Confidentiality, Problem Resolution, Advance Directives, Provider List, Acknowledgment of Receipt form and Cultural/Linguistic issues were reviewed.

Response: Client reported he understood the reviewed paperwork and information and that this is a process and he still needs to become approved for services. During the intake, the client responded to the questions to the best of his ability. He appeared nervous, fidgeting in his chair and was hesitant to answer some of the questions regarding his current symptoms and past behaviors. The client’s gaze was focused downwards for most of the intake, but he was respectful and responded to the questions in a polite manner. Near the end of the intake the client reported that he is “afraid of himself” and he “really needs help”.

Plan: The client was given a Yolo County Crisis card and was instructed on how and when to use the different numbers. The client agreed to use the appropriate crisis numbers if his symptoms increase. The information provided by the client during the intake assessment, along with the hospital records and past charts, will be reviewed to complete the written assessment with formulated diagnosis and recommendations/referrals for services. The completed assessment will be given to the supervisor for final disposition of services.

Re-Assessment - 90791

1.

P – Met with client in Davis Clinic to complete annual reassessment and other annual paperwork. Client has a hx of severe major depressive sx, and has been hospitalized three times in the past year for suicide attempts. Currently, Client reports hypersomnia, low appetite, difficulty concentrating, and poor memory, but reports no S/I or H/I. She is currently receiving medication services from YCHHSA and reports taking her medication regularly.

Diagnosis:
Axis I: 296.33 Major Depressive Disorder, Recurrent, Severe without Psychotic Features
Axis II: 799.9 Deferred
Axis III: 799.9 Deferred to MD
Axis IV: Problems with the social environment
Axis V: GAF = 50

I – The psychosocial reassessment is the intervention. The following information was reviewed, explained and Client signed in agreement: Informing Materials, HIPAA Privacy Practices,
Confidentiality and the Limits of Confidentiality, Problem Resolution, Advance Directives, Acknowledgement of Receipt form Provider List and Cultural/Linguistic issues.

R – Client was teary eyed while answering questions, and appeared to have difficulty focusing on the questions, as evidenced by her frequent hesitation in answering questions, apologizing, and asking this writer to repeat the question. While discussing client’s suicidal or homicidal thoughts, client denied any currently and verbally contracted for safety.

P – Will plan to meet with client next week to discuss and develop new treatment plan goals. Will plan to discuss case with supervisor.

2.

Met with client and parent in home in Woodland to complete intervention of re-assessment and annual authorization procedure. Client has a hx of disruptive behaviors, including throwing things at other people, fighting with peers at school, and being physically aggressive with younger sister. Client has been receiving services through this agency and with this writer for the past year, and has made some small progress on goals. Client continues to be disruptive in class (e.g., throwing pencils at classmates while the teacher is lecturing, not completing homework, walking out of class) and continues to have difficulty getting along with younger sister. Client has been suspended from school once in the past 6 months, and this was due to starting a fight with another student.

Diagnosis:
Axis I: 313.81 Oppositional Defiant Disorder
V61.8 Sibling Relational Problem
Axis II: 799.9 Deferred
Axis III: 799.9 Deferred to MD
Axis IV: Problems related to primary support group, Problems related to social environment, Educational Problems,
Axis V: GAF = 52

The following information was reviewed, explained, and signed by parent and client: Informing Materials, HIPAA Privacy Practices, Confidentiality and the Limits of Confidentiality, Problem Resolution, Advance Directives, Provider List, and Cultural/Linguistic Issues.

Mother provided a great deal of information for the assessment because client was unwilling to speak during the assessment, except to indicate that he felt that the child he was in a fight with “deserved it.” He refused to explain further about why he felt this way. Client sat next to his mother during the assessment with his arms crossed, refusing to make eye contact with this writer, but laughed when mother brought up the difficulties between client and sibling.

Will plan to meet with client and mother next week to complete new treatment plan and will discuss case with supervisor.
When interventions are directly related to addressing symptoms of diagnosis and areas mental health goals are focused on

1.

**P**- Met with client in the Woodland Clinic to address ongoing nightmares, flashbacks, and severe anxiety since client was raped by a former boyfriend. Client reported in this session that her former boyfriend also sexually abused her 4 year old daughter, and she was feeling guilty and depressed about this.

**I**- Discussed with client the need to report this information to Child Protective Services, and client was willing to make the report with this writer’s assistance. This writer called CPS, and provided support, encouragement and guidance to client as she provided information to the CPS social worker. After the report was made, this writer processed the experience with client regarding making the report and attempted to reframe the experience in an empowering way.

Also noted to the client that it was time to complete the treatment plan with goals for treatment for the client. This writer and client discussed the goals of increasing appropriate coping skills for anxiety (such as, writing, going for a walk, talking to a friend, or painting) and increasing assertive behaviors (such as speaking up for herself) to help client feel more empowered and to decrease overall anxiety.

**R**- Client reported feeling intimidated and fearful at first regarding the report, however she agreed that it was empowering and that she was doing the right thing to protect her child and possibly other children in the future. Client took the lead on formulating her goals, and indicated that she very much wanted to “get better” and have less anxiety. She was tearful during most of the session, but appeared calm prior to leaving today.

**P**- Will plan to follow up with the verbal report with faxing the completed written report. Will also complete the client plan in AVATAR to plan to review with client for signature at next week’s session. This writer provided client with the assignment of journaling her anxiety level on a daily basis, and will plan to review this with client at the next session, as well.

2.

Client was seen in West Sacramento office and she reports that she is having intrusive thoughts and nightmares related to a sexual assault she endured while homeless last year. She has not told anyone about this assault due to her self-blaming about the attack. Utilized cognitive techniques to help client understand that she was the victim and did not cause the attack. In addition, this writer explained Post Traumatic Stress Disorder (PTSD) manifestation. Client expressed that she felt some relief in discussing the attack, however she was not entirely trusting of clinician’s statement that she did not provoke the attack. Client is fearful of going to sleep tonight and experiencing a nightmare. Due to client’s severe mental illness, this writer is not referring client to Sexual Assault and Domestic Violence Center (SADVC) where she reported she would feel out of place. Will plan to use cognitive techniques and will consult with psychiatrist.
regarding possible medication changes. Will plan to monitor client closely to ensure she has sufficient support to prevent decompensation.

3.

Client was seen in Woodland Clinic to continue working on the goal of appropriately expressing feelings of sadness. Client expressed sadness about feeling rejected by others. This session was interactive because of the utilization of sand tray techniques. Worked with client on alternatives to feelings of sadness. During sand tray exercise, client placed a single donkey on a raised mound surrounding it as a moat with water. When asked the donkey’s name, client sheepishly replied “Blue Donkey, you know, like Eeyore? He’s always sad, just like me!” While working with client regarding alternatives to feelings of sadness, this writer attempted to assist client into thinking about who else could join the Blue Donkey on the island. Client placed a bridge across the moat and exclaimed “See, I done that!” Next she had a giraffe walk across the bridge to the donkey. When asked who the giraffe represented, client reported that it was her mother watching over her. Towards the end of the time, client reported that she felt better, and this writer observed client skipping out of the office to join her mother in the waiting area. The plan for next session with client is to work with client in identifying what makes her feel isolated and sad, and how to bridge those feelings constructively.

**Group Therapy - 90853**

1.

**Direct (Face-to-Face) Time:** 19 min. (93 min. x 1 staff = 93 min. / 5 clients = 18.6 min.)

**Documentation Time:** 6 min.

**P** – Client participated in a dual diagnosis group therapy session today in the Woodland office. The topic of the group was “What are my triggers that lead me to use?” Client is participating in group due to history of severe depression and dependence on multiple substances.

**I** – Each client identified their own triggers, spent some time processing through feelings and thoughts associated with their triggers, and, utilizing cognitive behavioral techniques, began to create a plan to avoid triggering situations.

**R** – Client expressed a commitment to maintaining sobriety, however, client is discouraged by the continuation of voices despite his medication compliance. Client reported he was surprised by the amount of support he received from the group. Client quickly identified two triggers: boredom and phone calls from his mother.

**P** – Client agreed to utilize peer support, community resources, or to call this clinician if he feels his condition is deteriorating. Clinician and client will consult with psychiatrist regarding voices.
2. 

**Direct (Face-to-Face) Time:** 49 min. (122 min. x 2 staff = 244 min. / 5 clients = 48.8 min.)

**Documentation Time:** 7 min.

Client participated in a group therapy session today in the Woodland office, facilitated by this writer and Clinician John Doe. The topic of the group was “How to keep my focus at school.” Client is attending group as part of client’s treatment for Attention Deficit Hyperactivity Disorder (ADHD).

The goal of this activity is to provide participants a way to identify distractions and redirect appropriate self-redirection themselves without getting frustrated or giving up in different settings. The group utilized a structured card game that required participants to maintain focus and tracking. Worked with clients on identifying how they felt internally when frustrated by the structured task. Progressive relaxation techniques, and self-soothing exercises, and time outs were also introduced. These were utilized to assist clients in this focusing activity as well as the use of “time-outs” as warranted and needed. Activities were utilized to assist clients in sustaining his/her focus on activities.

Client was initially disruptive and intrusive; interrupting both presenters and violating other participants’ space by taking away their cards and talking over her peers. This writer assisted client by initiating a time-out, then reintegrating client into the group by strategically helping client select a new seat where she could be more focused and less distracted. After the time-out and reintegration, client proceeded to engage successfully in the activity without further disruption.

The plan is to continue to work with client in choosing “seat placement” at the start of a group therapy activity that she has identified to be less distracting. Client will identify a “seat placement” that is less distracting. Will also plan to consult the teacher to ensure that client is in a “seat placement” that is less distracting in the classroom, so that client may be focusing will focus more easily.

**Collateral - 90887**

1.

**P** – Received phone call from Client’s Sister who indicated that she was very concerned about client due to a recent increase in client’s symptoms recently. Sister reports that client is not sleeping well, is becoming increasingly manic and appears to be hearing voices and having visual hallucinations again.

**I** – Gathered information from sister, and asked if she knew if client was continuing to be compliant on his medications. Sister reported that she did not know. Discussed whether or not client would be willing to come in to speak with writer today, and sister reported that client “took off” this morning, and has not been back. Provided contact information for crisis services, and instructed sister to call this writer when if client returned.
R – Sister reported she would contact this writer, and she indicated she planned to contact friends of client, and places that client liked to “hang out at.”

P – Will discuss information with client’s psychiatrist, crisis team, and supervisor, and will plan to follow up with sister later regarding whether or not client has been located.

2.

Placed phone call to mother today regarding client’s progress on client’s star chart. Mother reported that client experienced a set-back this past week when client “blew out” in school, resulting in a one day suspension. According to mother, client was being redirected to her seat following an outside activity at school, but was having difficulty in following the teacher’s instructions resulting in client being frustrated and “throwing a chair at the teacher.” Worked with mother in identifying the events that led up to client’s “blew out”, including a recently failed visit with her father the night before the incident. Encouraged mother to continue to use the positive reinforcements to assist in redirecting client when client is frustrated. Mother agreed to continue to use the positive reinforcements with client. Mother expressed frustration over how slow progress seems to be occurring. Will report this incident to client’s therapist for her next follow up at session. Will also plan to contact mother at the end of the week to check in regarding client’s behavior in school.
APPENDIX D: Sample Notes for Medical Codes

E/M Codes/Medication Support (MD/DO/NP/PA) – 99211-99215 (established clients)

1.

S: ID: Patient is a 45 y/o female with h/o Schizoaffecive Disorder seen face to face at West Sacramento Clinic for a psychiatric follow up visit in a confidential setting. CC: "I'm still having anxiety." Interval History: Chart partially reviewed. Patient reports that she self-discontinued Vistaril secondary to feeling worsening of restless legs with the medication and that she also self-discontinued Prolinxin secondary to feeling increased tremor with the medication. At present she reports having ongoing episodes of anxiety including tachypnea without clear precipitant. She however reports fair sleep plus self-care and denies depressed mood, anhedonia, hopelessness, SI, HI, or thoughts of harming herself or others. She denies worsening of baseline occasional AH and while she reports visual illusions of seeing things from the corner of her eyes she is without clear visual hallucinations or frank delusions. Patient denies elevated mood or increased goal directed activity. Patient denies recent substance use including no cigarettes. No other acute complaints.

O: ALL: NKDA; Medications: Depakote ER 1000mg PO BID; Invega Sustenna 234mg IM q 4 weeks (last on 1/7/16); Prolxin 2.5mg PO QD PRN plus 2.5mg PO BID (not taking); Cogentin 1mg PO BID; Prozac 40mg PO daily; Vistaril 50mg PO daily PRN (not taking); also takes Melatonin 1mg to 3mg PO qhs PRN over the counter as well as medication for RLS, GERD, as well metformin, and levothyroxine from PMD; Prior Medication Trials: Vistaril (worsened restless legs); Wellbutrin (inadequate effect); Prolinxin (tremor); Labs/Diagnostics: 6/9/15 FLP, TSH, CBC, plus CMP unremarkable except glucose 103mg/dL, and VPA 73.6 mg/L; Physical: Vitals: HR 93, BP 127/73, Ht 59 inches, Wt 245.2 pounds; mild tremor on outstretched arms but no abnormal involuntary movements noted today and 1/29/16 AIMS score zero; MSE: Appearance/Behavior: fairly groomed overweight female appearing stated age in no apparent distress. Patient has fair eye contact, is calm, cooperative, with no PMA/PMR; Speech: non-pressured and fluent, normal latency, amount, and volume; Language: intact; Mood: not depressed or euphoric; Affect: blunted, stable; TP: goal directed; Associations: intact; TC: No SI, no HI or assaultive ideas, no frank delusions; Perceptual disturbance: denies current AVH, not internally preoccupied; I/J: fair; Sensorium: Alert, awake, grossly oriented; Fund of knowledge: intact

A: Patient with a history of Schizoaffecive Disorder who presently reports some ongoing mild anxiety and occasional baseline AH but who is without acute psychiatric decompensation and without acute worsening of functional impairment. Patient has no suicidal ideation, homicidal ideation, or current dangerous behavior, and remains stable for continued outpatient care at this time. Axis I: Schizoaffecive disorder; h/o methamphetamine abuse; Axis II: deferred; Axis III: hypothyroidism; NIDDM; Axis IV: social stressors; Axis V: 55
P: Treatment goals include management of psychotic, mood, and anxiety symptoms. Increase Cogentin from 1mg PO BID to 1mg PO TID for EPS given her complaint of ongoing mild tremor. Formally discontinue Prolixin 2.5mg PO BID plus 2.5mg QD PRN as she already self-discontinued this secondary to worsening tremor without worsening of psychosis, but continue Invega Sustenna 234mg IM qmonth for presently fairly controlled baseline psychosis. Start Buspar 15mg PO BID for anxiety and formally discontinue Vistaril 50mg PO QD PRN which she already self-discontinued. Continue Prozac 40mg PO daily for mood plus anxiety. Continue Depakote ER 1000mg PO BID for mood stabilization. One month prescription with three refills ordered. No labs ordered today. Patient states that she is not pregnant at present and that she would inform staff if she decides to become pregnant in the future so as to evaluate treatment options at such a time in order to minimize fetal risk. Patient encouraged to continue to abstain from substances of abuse. Brief supportive therapy and psychoeducation provided. Patient encouraged to maintain regular follow up with their primary care physician for management of medical problems and routine health maintenance. Follow up with psychiatry in about one to two months, but patient agrees to request a sooner appointment if needed and to call 911 or go to the nearest emergency room in case of an emergency.

E: Risks, side effects, benefits, and alternatives including no treatment were discussed with simple syntax and vocabulary and patient expresses agreement with the plan. Medication consents signed 1/29/16 for Buspar as well as on 9/18/15 for Prolixin, Invega Sustenna, Depakote, Prozac, Cogentin, and Vistaril.

2.

Previously Diagnosed with: SCHIZOPHRENIA, Paranoid type
On LPS Conservatorship: Yes
Chart reviewed. Met with pt.
Psychiatric Medications:
Consta 50 mg IM every 2 weeks
Neurontin 300 mg TID
Latuda 80mg PO QD
Cogentin 0.5mg BID
Other meds: oxybutynin, Flonase prn, Colace BID
Med Compliance: good
s/e, a/r, other med issues: denies
Interval Hx: Pt continues to present with overvalued ideas re: "all her kids" and she talks about being "exasperated having all the babies taken away from me" and I had to have milk removed from me." It reportedly went on for 40 years and last time it reportedly happened was 1994." Feels obligated (by herself) to set up the table and do chores at the B&C despite experiencing arm pain
Pt endorses the ffg:
Mood- overall, "pretty good."
Sleep- 8 hours/night
Appetite- "good"
Energy fair "but I have to rest a lot."
Concentration- fair Hal- denies SI/HI- denies
Being on LPS- "helping, don't have to worry about record keeping"
Stressors: CMI, s/p chole (back pain improved)
SS: conservator, B&C staff
Alcohol: Denies/None Drugs: Denies/None
Cigarette: not smoking cigarette but chews tobacco ("very little")
Caffeine: 1-2 cups of coffee a day
Update on Psychiatric/Medical History:
Recent Inpatient: Denies/None
Recent Suicide attempts/gestures: Denies/None
On-going psychotherapy/other psych services: Yes: Tues group session
Pregnancy: N/A Breastfeeding: Denies or N/A
Allergies: sulfa

Mental Status Examination:
Appearance: WF overweight, dressed casually Ambulation: unremarkable
Psychomotor Aberration: none Behavior: Cooperative, NAD
Speech: NRRT Eye Contact: Adequate/good
Mood: "pretty " Affect: broad
TC: (-)hal (+) del (-) SI
Internally pre-occupied: No
Guarded: No
TP: tends to be circumstantial and tangential
Cognition: Alert Orientation: (+)poor
Risk Assessment:
Suicidal Ideation: Denies Plans: Denies Intent: Denies
Homicidal Ideation: Denies Plans/Intent: Denies Tarasoff needed: No or N/A
5150 Not meeting any criteria for being DTS/DTO

ASSESSMENT: Schizophrenic DO, Paranoid Type chronic obesity, bladder incontinence; S/P CHOLE Response to treatment: partially responding to meds

PLANS:

3.

1. Medication management: New Medications prescribed: no
Consta 50 mg IM every 2 weeks
Neurontin 300 mg TID - to help with anxiety, nerve pain, mood regulation
Latuda 20mg po qam to Latuda 60mg po qhs- to address worsening of her delusional thoughts.
Cogentin 0.5mg BID- to still help with EPS but with less s/e of dry mouth
Note: r/b, s/e profiles, treatment options discussed with pt; instructions given; informed consent obtained; provided opportunity to ask questions
2. Provided Psycho- education and Supportive Psychotherapy
3. Group session q Tues at YCMH
4. Continue on-going tx/services with other providers including: PCP
5. Other: relaxation technique, behavioral mod
6. Crisis intervention plan previously discussed with pt (or legal guardian) including ER/911 utilization for medical or psychiatric crisis
7. RTC in 4 weeks and PRN
8. LPS affidavit completed and signed as pt still lacks mental capacity to receive, process and make appropriate plans for her food/shelter/clothing w/o the structure/benefits of conservatorship.

4.

SUBJECTIVE:
Patient reports, she is not doing well, she doesn't like to be alone, she has been more paranoid, she thinks that she has been exposed, people can hear her. Sometimes she feels they may be out to get her. She thinks people are judging her and talking about her. She has been feeling this way since she broke up with her boyfriend and moved to West Sacramento area with her roommate. She had bad experience with her ex-roommate. She is afraid of being alone, she is anxious about being single, because "I have been with my boyfriend for 5 years". She has support of her mother but she lives 2 hours away. She has support of case manager and staff in turning point.
She denies hearing voices or visual hallucinations. She doesn't feel depressed but she feels anxious. She doesn't report any hypomanic symptoms. She has been consistent with medication, denies any side effects.
She denies any suicidal or homicidal thoughts.
She denies being abused by her ex-boyfriend. "He was controlling, when he kicked the door, I left him". She thinks that he may have been cheating on her.
She denies any physical health problems, except for mild acne type of lesion on her breast. She had it for the last 5 months. She is going to see PCP next week for an all checkup and talk with her about the lesion.
She eats and sleeps well.
Current medication:
Saphris 10 mg one twice a day for more than a year
Risperdal Consta 50 mg IM every 2 weeks since 2012
She has been consistent with medication, denies any noncompliance
She denies any side effect. Denies EPS symptoms. Aims was negative today
She reports Saphris has been very helpful in reducing her paranoid thoughts and racing thoughts.
She doesn't feel paranoid, and doesn't have unusual thoughts.
Patient reports she has been tried on Invega Sustenna but it was not helpful.
Past history:
_____ gives history of feeling paranoid in the past, thinking that people are talking about her, camera was watching her, she had grandiose thoughts of God speaking to her, and thoughts of being a movie star.
She reports she used to have manic symptoms, very high energy level, couldn't sleep, wandering on the streets, and irrational thoughts. She gave the example that one of her favorite musician is in love with her. She still has crush on him but she understands that he is not in love with her.
She reports she never had depressive symptoms, she never had hallucinations. She would get very paranoid and grandiose, and had manic symptoms.
She has been pretty stable since August of last year after she started on Saphris in combination with Risperdal injection
Medical history:
She denies any physical health problems except for obesity.
Patient reports she can lose weight, but she needs to get herself motivated. She has done it in the past she denies taking any medication for physical health problems.
PREGNANCY: denies OR N/A
Patient was referred to Primary Care Physician for regular follow ups.
VITAL SIGNS: Please refer to nursing note for more information.
PCP: Dr. Jason Rose, Peterson Clinic
Pharmacy: Raley's, Woodland
Drugs and alcohol: patient denies drug and alcohol use. she drinks wine, one bottle in one week
LAB: results from May 13, 2014, indicates hyperlipidemia, cholesterol total 213, triglycerides 175, LDL 133, a copy of lab results was provided to take to PCP
Healthy diet and exercise was recommended.
OBJECTIVE
Mental Status exam:
Appearance good, obese, dressed casually and appeared well Kempt
Behavior: normal, interactive and pleasant, preoccupied
Eye Contact: good
Speech: spontaneous, short pauses
Mood: Mildly dysphoric, anxious, sometimes guarded
Affect: Full, congruent,
Thought Process: linear, goal directed, mild thought blocking, some thought broadcasting
Thought Content: paranoid thoughts
Thought perception: Normal and no hallucinations
Safety Assessment: Patient denied any suicidal or homicidal ideations, plan or attempt.
Orientation: Alert and oriented x 3
Judgment/Insight: Fair
DIAGNOSIS:
Axis I: Bipolar 1 disorder vs schizoaffective disorder
Axis II: deferred
Axis III: GERD, Asthma
Axis IV: chronic mental illness, breakup with boyfriend, living alone, housing problems
Axis V: Current GAF 45
ASSESSMENT & PLAN: patient is presenting with recurrence of psychotic symptoms, mostly paranoid thoughts, denies any mood symptoms or hypomanic symptoms. She sleeps well. She is having a hard time being alone. Transitioning to new apartment has been successful. plan is for patient to move to a new apartment in Woodland which she likes it better
She has no contact with her ex-boyfriend.
We talked about adding Risperdal oral with a low dosage to help with paranoid symptoms. Patient agreed with treatment and plan.
She also mentioned something about not wanting to take any medication "is that a good idea", but she was able to change her mind quickly, when I emphasized that medication is important and she should not consider discontinuing it at this time. she had great to continue to take current medication and additional Risperdal.
Plan:
Continue Risperdal Consta 50 mg IM every 2 weeks
Continue Saphris 10 mg one twice a day, she is taking maximum recommended dosage
Start the Risperdal 2 mg 1 by mouth at bedtime
Patient was advised about EPS symptoms, she will call as needed
Atypical panel has not been done,. She had lab slips, she agreed to do it in the next week
Continued case management. She has been seeing her case manager weekly.
We discussed current medication effects and side effects, risk/ benefits, advantages and disadvantages. Verbal/Written Informed Consent to take medication was obtained. Instruction was provided.
Psycho-education and supportive therapy was provided.
Patient was advised to continue ongoing treatment/services with other providers including PCP
Patient was advised on healthy diet, exercise and sleep hygiene.
Patient was advised on crisis intervention plan including ER/ 911 utilization for medical or psychiatric crisis.
Follow-up appointment in 2 weeks or sooner as needed.

Medication Support (RN/LVN/LPT) – 90899

1. SAMPLE NOTE FOR CLOZARIL CLINIC

S: Client presents to clinic today for follow-up of Clozaril medication management and symptoms of Schizophrenia. Met with the client in confidential setting. Client states, “I am feeling quite well”, and denies experiencing any adverse effects from Clozaril since last seen by writer two weeks ago. She reports good compliance by taking her medication as prescribed and always at the same time each day. She also reports good compliance with lab draws and gets her blood drawn every two weeks as ordered. In response to her symptoms stability and how she thinks the medication is helping, client responds, “I think it is what keeps me stable”.

O: Reviewed vital signs and lab results from Clozaril clinic visit two weeks ago to compare with current vitals and labs and identify if there are any significant changes or concerns.

Measured vitals today. Vital signs stable:
BP 125/82
Pulse 80 and regular
Respiration 16 and even
Temperature 98.4F
Current weight: 156 lb. Weight is noted to be a gain of 2 lb. over the last 4 weeks. No concern at this time.

Blood work (previous on 8/1): WBC 5.4 ANC 1.8
Blood work (current today 8/15): WBC 5.6 ANC 1.7

Client is in her eighth month of Clozaril therapy and on a monitoring schedule of every 2 weeks per the TEVA Clozapine protocol. Vitals and labs are both stable and client has not required any blood re-draws for unsafe changes in WBC or ANC values.

Client presents mildly disheveled but without odor and dressed appropriately for weather. Calm and cooperative. Speech is normal rate, rhythm, and volume. Makes good eye contact. Alert and oriented x3. Her mood is “good”, affect euthymic and congruent to mood. She denies SI, HI, AH, and VH.
A:

Clozaril Medication Management: Good compliance. Adherent to both medication and blood work regimen prescribed. No reported or observed adverse effects or complications. Labs and vitals stable.

Mood Symptoms associated with Schizophrenia (per MD diagnosis): Client denies current symptoms and she appears stable.

P: Reviewed with client signs and symptoms that may indicate an exacerbation of her Schizophrenia. Provided education on lab values and when client would be notified if a re-draw is required. Discussed signs and symptoms that may be associated with significant changes in WBC or ANC, and when to call the nurse or doctor. Provided education on monitoring protocol and Clozaril dosing. Provided time for client to ask questions. Client will follow-up with next blood draw at the lab in two weeks on 8/29, and continue with Clozaril clinic with this writer every two weeks. Client will continue on current dosing of Clozapine 200mg PO BID per MD order. Client will call or request sooner appointment if any changes or problems arise in the next two weeks. Praised and encouraged client to maintain her compliance. RTC in two weeks on 8/29.

2. SAMPLE NOTE FOR MED ISSUE PHONE CALL FROM CLIENT

P: Client left message on nursing line regarding concern about a medication reaction and requesting call back. Writer spoke with client to discuss her concerns, help determine the nature of the problem, and what might be done to assist her in feeling better and alleviating her concerns. Client reported to writer that “there are these small red spots all over my arms, chest, and back. And I am itchy”.

I: Discussed with client any recent medication changes, and any new foods eaten or changes in hygiene/body products to rule out other possible sources of a reaction. Client denies having eaten anything new and denies making any changes to the products she uses daily. Reviewed medication list and changes with client, and it is noted that her doctor adjusted medications two days ago. Reviewed medication profile for new medication prescribed, Lamictal, and side effects associated with it. Reviewed with client her presenting symptoms. Consulted with client’s primary MD to discuss the medication reaction and recommended course of action. Provided education to client on new instructions and follow-up per MD orders. Provided education to client on new medication prescribed by MD, reviewed medication profile, side effects, and offered client opportunity to ask questions. Verbal consent obtained by client for Risperdal, and will have her sign written consent at next appointment. Client advised that MD recommends over-the-counter Benadryl as labeled on the box, to help with the itching, and if no relief, to call back and a prescription for Vistaril can be ordered. Notified client that writer will call her tomorrow for follow-up.

R: Client was started on Lamictal two days ago to target her mood symptoms of Bipolar Disorder (per MD diagnosis), after having limited response to Depakote and Lithium. Client
states she began having itching and only a few red spots scattered on her chest after taking the first dose. When she awoke this morning after the second dose last night, she observed small, round, red spots covering her chest, arms, and back. Client also reported feeling itchy. She denies having any difficulties breathing or swallowing. She denies any swelling. She does not observe any rash on her neck or face. Client denies feeling like she is having a racing heart rate or palpitations. Client denies chills or sweating. She was able to check her temperature at home and it is normal at 98.9F. Client reports her only discomfort at this time is the itching. Writer’s assessment of the presenting problem is that client is experiencing an allergic reaction in the form of a rash from Lamictal. Client verbalizes understanding of medication changes made by MD. Client is able to repeat back the instructions for how to take new prescribed medication, and that this information will also be reviewed by pharmacist upon picking up medication. Client states understanding of when to call back to MD or seek immediate medical attention. Client denies questions at this time. Client’s chart updated by writer to reflect Lamictal as an allergy that causes rash.

P: Client will discontinue Lamictal per MD order due to rash and appearing to have allergic response. Client will begin taking Risperdal 1mg PO BID per MD order. Client will use over-the-counter Benadryl as needed and labeled on package to help alleviate itching. If rash worsens or client notices new or life-threatening symptoms, she will seek immediate medical attention at the emergency room. If client continues to have itching not alleviated by Benadryl, she will call back to request prescription from MD for Vistaril. Client will follow-up with primary psychiatrist in one week due to medication adjustment, or sooner with nurse, if needed. Client will call clinic if any issues or questions arise.

3. SAMPLE NOTE FOR SYMPTOM/BEHAVIOR ISSUE WITH CLIENT PRESENT

S: Client presents to walk-in clinic requesting to see nurse because of a stressor making her feel very depressed. Met with client in confidential setting to discuss her stressor and explore her feelings and symptoms. Client states, “I’m not doing well at all. I just lost my best friend. She was involved in a car accident. She was my only friend and now I have no one to talk to”. Client feels that the occurrence of this event was a significant stressor to her depression and has worsened her depression and triggered some new symptoms. Client states, “I don’t know how to go on right now. How do I process this? Maybe I shouldn’t even try. It’s too bad I just wasn’t in the car with her”. Client expresses that she is unable to stop crying and having negative thoughts. She feels she is moving into a dark place but is wanting to seek help.

O: Client presents disheveled and unkempt with messy hair. She is tearful with puffy red eyes likely from excessive crying. She is holding several tissues in her hand that she uses continually to wipe her eyes and nose. She sits slumped over in the chair with a blank stare at the floor. She gives dispassionate responses and appears to have some passive suicidal ideation. Client’s speech is soft, slow, and difficult to understand at times because of crying. Poor eye contact, will not look at writer. Her mood is “dark and depressed”. Affect is sad, dysphoric, appears consistent with her mood. Thought process linear, perseverative on loss of friend and how to cope and grieve. Client endorses passive suicidal thoughts of
wishing she died with her friend in the accident but denies intent or plan at this time and wants help, somewhat future-oriented. Client denies HI, AH, VH. Alert and oriented x3. Attention and concentration impaired, as writer has to frequently redirect her to interview and questions asked.

A: Based on subjective and objective findings, writer’s assessment includes the following nursing diagnoses:

1. Grieving related to loss of significant support person as evidenced by reported feelings of despair, despondent responses, inability to stop crying, impaired concentration and attention, and feelings of guilt versus moving forward.

2. Hopelessness related to depressed feelings as evidenced by despondent responses, looking down and refusing to make eye contact with writer, and unsure how to process or cope with loss.

3. Impaired mood regulation related to depression and anxiety as evidenced by impaired attention and concentration, uncontrollable crying, and thoughts of living versus dying.

P: Explored with client her feelings and how she might be able to process them. Provided education to client on coping mechanisms and assisted her with identifying a few that may work for her in this situation. Assisted client with identifying any other supportive people in her life, including family, to surround herself with others for support and avoid isolation. Discussed and developed with client a crisis plan and provided suicide hotline number. Encouraged client to utilize this number, 911, or go to the nearest emergency room if she feels suicidal and/or having impulsive feelings. Client provided with urgent follow-up appointment with primary psychiatrist tomorrow to further determine if any medication adjustments are needed or additional short-term services can be offered at this time. Encouraged client to attend grief counseling and process groups to learn coping skills. Encouraged client to continue to try to maintain her daily routines to the best of her abilities to provide some type of normalcy and distraction.

4. INJECTION CLINIC

P: Client is here for his routine injection clinic appointment at the Woodland clinic. He receives his injection Q 4 weeks for management of Schizophrenia symptoms and maintaining medication compliance for stability and functioning in the community.

Vital Signs:
Ht: 5’11”
white male, appearing older than stated age; calm, cooperative
Wt: 208 lb
BMI: 29.3 articulate
BP: 119/86 at times; denies SI/HI/VH but endorses occasional baseline AH and mild paranoia
HR: 74

MSE:
Appearance/Behavior: fairly groomed, overweight
Eye Contact: fair
Speech: slightly pressured but normal tone, volume, TP/TC: goal directed, mostly linear though tangential at times; denies SI/HI/VH but endorses occasional baseline AH and mild paranoia
Mood/Affect: stated mood “okay”, affect blunted

65
Substances: Client denies use of illicit drugs or ETOH. He smokes ½ ppd cigarettes. Drinks 1-2 cups coffee/day.

Med s/e: Client denies, none observed.

Med compliance: Good adherence, has only missed one injection appointment in the last 6 months.

Rx: Invega Sustenna 156 mg IM Q 4 weeks (per MD order)

Client presently reports occasional AH of mumbling voices that are at his baseline and non-bothersome. He also reports mild paranoia but is able to go about his day.

I: Reviewed medication/Rx with client. Provided brief education review on side effects and benefits vs. risks of continuing treatment as ordered by MD. Praised and encourage client for his compliance. Injection administered to client by this writer in his left deltoid.

R: Client verbalizes understanding of potential med s/e and importance of compliance to prevent worsening of symptoms and psychiatric decompensation. Client denies any questions at this time. Client tolerated injection well. His only complaint is mild arm soreness at injection site that occurs the following day but resolves within 24 hours. He denies experiencing any redness or swelling at site.

P: Client appears to be at his usual baseline and continues to be stable. Client will return to injection clinic with this writer in 4 weeks. Client will continue receiving Invega Sustenna 156 mg IM Q 4 weeks per MD order, unless otherwise noted that Rx changed by MD. Client will follow-up with MD appointments as scheduled. Client will call with any questions or problems that arise before his next MD and/or injection clinic appointment.

5. VITAL SIGNS

P: Client presents to the West Sac clinic for her routine follow-up appointment of depression, anxiety, and medication management with Dr. ________. Client c/o feeling highly anxious the last two weeks to the point she “cannot do anything but sit in the house”, which is making her feel more depressed. Client would like to address these issues with the MD during the session and discuss medication adjustments.

I: Explored with client any stressors or recent changes to help identify triggers. Discussed some coping strategies with client that may help to manage her emotional control. Encouraged client to utilize nursing line and call when needing help or experiencing any worsening of symptoms. Measured and reviewed vital signs for any abnormalities and ensure vitals are stable/appropriate for any meds that may be prescribed and/or if medical follow-up is needed by PCP.
R: Client cooperative with vital signs being taken:

Ht: 5'6"
Wt: 118 lb
BMI: 19
BP: 108/76
HR: 98
Resp: 22
Temp: 97.6

Client’s pulse and respiration are noted to be mildly elevated, which could be due to her highly anxious presentation and constant fidgeting. Client denies pounding or racing heart, palpitations, or difficulties breathing. Client does not appear to be in acute distress.

P: MD notified by writer of vital signs and client’s presentation prior to appointment. MD made aware of client’s desire to address her exacerbation of symptoms and adjusting medication(s). Client will follow-up with MD in today’s session.

Medication Refill/Comprehensive Medication Services- H2010A

Writer/Nurse was informed by____of need for medication refill. Chart record reviewed. Chart record indicates Dr____previously ordered RX for____drug/dosage/instruction for____symptoms related to____diagnosis. Writer contacted client (or case manager) who reported______. Client/CM shared that medication alleviates____(symptoms, and allows client to engage in____(address functional impairment). Writer reviewed client’s medications with her and confirmed proper independent usage and administration. (Provide instruction in the use, educate on the risks and benefits of, and discuss alternatives for medication.) Consulted with MD and provided information gathered. (Provide details of revised/continued order per psychiatrist). Writer contacted pharmacy (provide name and location of pharmacy) to provide authorization (or) Rx orders provided to pharmacist as ordered by MD. Orders read back and verified for accuracy and appropriateness of Rx. Writer followed up with client and case manager with notification and update of the refill request (completed or denied with further instructions to come in). (Document why the medications is a necessary to alleviate sx of mental illness and its clinical effectiveness, and also include reasons meds are not taken, reason client requires education and assistance from team to maintain adherence, any adverse side effects or possible contraindications).

P: MD____authorized refill for____(duration) and client was provided information on next scheduled appt (and encouraged to speak with case manager for continued medication education for ongoing adherence to regimen). Case Manager was reminded of client’s lab requirement (or other pertinent case management tasks to be completed). USEFUL WORDING AND PHRASING
APPENDIX E: Helpful Tips

Rehabilitation activities (all with a focus of symptom reduction with the goal of improving functioning)

- Assisting client to process through thoughts and feelings regarding a certain event
- Assisting with a specific problem area
- Identifying obstacles
- Showing client how some obstacle might be overcome
- Helping strategize with client about what they can accomplish.
- Education regarding how symptoms/problem behaviors are interfering with his/her functioning
- Education about how symptoms/problem behaviors might be managed

Useful Phrases (be sure to follow with a description of specific, individualized interventions)

- Assisted client with accessing community resources for an extended period of time/in a variety of settings.
- Assisted client with accessing opportunities to interact with others/peers in a social setting/out in the community.
- Brainstormed with client possible alternatives to… behavior describe alternative to his/her behavior
- Client seemed attentive to modeling/redirection.
- Role modeled appropriate interactions with_____ continually throughout our meeting…
- Consulted with …to assist client with his/her behavioral goals/plan. (case mgmt.)
- Assisted client in developing increased skills regarding money matters/hygiene/personal safety/the usefulness of an education…
- Engaged client in a problem-solving session regarding…
- Upon this staff’s arrival, client appeared/seemed/looked to be in a …describe the mood then follow with a quality statement i.e. bright affect, flat affect, friendly disposition/demeanor, talkative, etc.

Avoid and Not Billable (utilize non-billable codes e.g. Indirect Unbillable/Direct Unbillable to show work done and other efforts to support clients in reaching goals even if not billable)

- Shopping for and with clients
- Using subjective statements (must use words like seemed, appeared, etc.)
- Training/Job Coaching of clients
- Transporting/Driving clients
- Naming of specific community locations (Macy’s, Valley Fair, Raging Waters, the beach, etc.)
- Providing material items or purchased items
- Naming specific recreational activities soccer, video games, movies, park, etc.)
- Working with client support persons on their own mental health issues/stressors
- Prepping for session/visit
- Completing/Faxing/Reviewed records and/or paperwork
- Leaving messages for clients, community and internal programs for clients, and other providers
APPENDIX F: Some Interactive Verbs Useful in Writing Progress Notes

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<th>accessed</th>
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APPENDIX G: Some Client Responses to Interventions

- Appeared interested/uninterested
- Agreed to
- Client’s behavior mimicked/paralleled staff’s
- Client modified his/her behavior
- Complied with expectations Did not respond
- Cooperated and adhered
- Initially…
- Listened quietly
- …Limited response
- Made eye contact
- Negotiated
- Nodded
- Receptive
- Refused to
- Responded age-appropriately
- Responded (in) appropriately
- Was receptive
- Smiled
- Was able to de-escalate
- Was responsive
APPENDIX H: General Progress Notes Checklist

GENERAL PROGRESS NOTES CHECKLIST

1. Are client’s presentation and response documented?
2. Are client’s progress or lack thereof documented?
3. Does this note connect to the client’s individualized treatment plan?
4. Does this note have all necessary sections completed in Avatar?
5. Is the correct client name and identifier selected in Avatar?
6. Has referral information been documented?
7. Are client strengths/limitations in achieving goals noted and considered?
8. Are any abbreviations used standardized and consistent?
9. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?
10. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?
11. What safety issues were present? Are there any safety issues that need to be monitored?
12. Medical Necessity: What is the primary diagnosis and which symptoms were addressed?
13. Functional Impairments: What are the mental health, daily living, co-morbid issues, and community functions that are still not resolved?

P.I.R.P Progress Note Checklist

1. PRESENTING PROBLEM/PLACE
   a. Place and people involved
   b. Reason for the contact
   c. Medical necessity/Functional impairment(s)
   d. Assessment of client’s current clinical presentation
2. INTERVENTION (or what was attempted by the clinician)
   a. Specific mental health/clinical intervention(s) by provider, per type of service and scope of practice
   b. Information provided
3. RESPONSE
   a. Client’s response to intervention(s)
   b. Unresolved issues from previous contacts
   c. Information received
4. PLAN
   a. Plans, next steps, and/or clinical decisions.
   b. If little or no progress toward goals/objectives, describe why.
   c. Include date of next planned contact and/or clinical action.
   d. Indicate referrals made
   e. Address any issues of risk
At a minimum, Rehabilitation, Therapy, Collateral, Crisis Intervention, and Targeted Case Management progress notes need to contain the following elements:

Progress notes must describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning that is outlined in the client’s Treatment Plan.

a. Timely documentation of relevant aspects of client care, including documentation of medical necessity
b. Documentation of client encounters, including relevant clinical decisions, when decisions are made, and alternative approaches for future interventions
c. Interventions applied, client’s response to the interventions and the location of the interventions
d. The date that the services were provided
e. Documentation of referrals to community resources and other agencies, when appropriate
f. Documentation of follow-up care, or as appropriate, a discharge summary
g. The amount of time taken to provide the services
h. The signature of the person providing the service, and as appropriate, the signature of the supervisor of the person providing the service

D.A.P. Progress Note Checklist

DATA

1. Subjective data about the client—what are the client’s observations, thoughts, direct quotes?
2. Objective data about the client—what does the service provider observe during the session (affect, mood, appearance)?
3. What was the general content and process of the session/visit?
4. Was homework reviewed (if any)?
5. What goals, objectives were addressed in this session/visit?

ASSESSMENT

5. What is the client’s understanding about their symptoms, diagnosis, problem, and impairments?
6. What is the service provider’s impression of how client is responding to treatment/service?
7. What are the results of medication, homework practice, skills building, and community linkages?
8. What is the client’s current response to the treatment plan/interventions?

PLAN

9. Based on client’s response to the treatment plan/interventions, what needs revision?
10. What is the service provider going to do next?
11. When is the next session/visit date?
B.I.R.P. Progress Note Checklist

BEHAVIOR (service provider observations, client statements)

1. Subjective data about the client—what are the client’s observations, thoughts, direct quotes?

2. Objective data about the client—what does the service provider observe during the session (affect, mood, appearance)?

INTERVENTION (service provider’s methods used to address goals and objectives, observation, client statements)

3. What is the service provider’s understanding about the problem?

4. Utilize “Useful Wording and Phrasing” section as appropriate

5. What was the general content and process of the session/visit?

6. Was homework reviewed (e.g., journal, reading assignments – if any)?

7. What goals, objectives were addressed this session?

8. What did you attempt to accomplish with the client?

9. If you modified the intervention; how did you modify it as appropriate?

RESPONSE (Client’s response to intervention and progress made toward tx plan goals and objectives)

8. Client’s response to the treatment plan, what needs revision?

9. What is the client’s current response or reaction to the intervention?

10. How do you see the client moving or not moving toward the goal? If very little or no progress, explain why.

11. Utilize “Useful Wording and Phrasing” section as appropriate

PLAN (Document what is going to happen next)

12. When if needed, will the treatment plan be revised?

13. What are the plans for continuing to work with this client?

14. What is the next step you are planning to carry out?

15. What is the service provider going to do next?

16. When is the next session/visit date?