Progress Note Clinical Guidance

What information is needed or necessary in your progress notes?

- Weaving the Golden Thread:
    - The progress note must include the client's functional impairments and should be connected to their mental health diagnosis or symptoms of their diagnosis (i.e.: "impairments in self-care, social functioning and living skills related to Bob's diagnosis of Schizophrenia," or "impairments in self-care, social functioning and living skills related to Bob's symptoms of intrusive thoughts, auditory hallucinations and disorganization").
    - While it is not required that it be documented in the progress note, the PSC should consider how the service being provided relates back to the client's treatment plan goals.
    - The Intervention section should link the interventions provided by the PSC to the functional impairments listed. The Response section should link the response of the client to the effects of the intervention.
    - The Plan section should include relevant next clinical steps in relation to the Intervention and Response sections, especially when a large clinical event occurred (i.e.: client was triggered by the intervention, so the Plan section should document PSC steps to address changing interventions; or client reports increase in MH symptoms, so the Plan section should document need to increase interactions with client or to consult with client's MD).
- How to gather information for your Response section: Ask your client!
    - Ask your client if the intervention you provided was helpful or useful. Ask your client if they can envision utilizing the skills taught in the session, when they are on their own?
    - Eliciting feedback from our clients not only provides information for us to guide treatment (and gives details to add to progress notes), but also increases our clients buy-in to engage in services. A client's treatment should be driven by the client, and in order for that to work, we need the client's feedback on their treatment.
- Crisis Intervention Notes
    - The first step is to determine if the service was a crisis service or not. Think through, "Do I need to respond right now or within 24 hours?" If it is determined that the intervention can wait until your scheduled appointment at the end of the week, then it would not be a crisis service. However, if you determine that the rapid response is necessary ("within 24 hours") then it would be appropriate to bill the service as Crisis Intervention.
        - While there may be times that the PSC is able to respond rapidly (i.e.: a client walks into the office without an apt and the PSC is available to

meet with them, or a client calls with a need and PSC is available to respond), that does not make the service a Crisis Intervention. The PSC must consider, "What would happen if we/I didn't respond right away?" If the answer is, "The client would've gone into crisis," then the service would be considered Crisis Intervention. However, if the answer is, "The client would've been fine to wait until our next meeting," then the service should be billed to the appropriate code (TCM, Collateral, Rehab, etc.).

- Remember: even if the intervention works (i.e.: "while client initially presented with SI, but was able to complete a safety plan, engage with family for support, and agreed to increase contact with IRT for the next 2 weeks, client did not meet criteria for a 5150 hold,"), if the PSC responded to the client/situation as if it were a crisis, then the service should still be billed as Crisis Intervention.
- The progress note itself must document the need for urgency, the outcome of the intervention (i.e.: whether or not client met criteria for a 5150 hold), and reasoning for why certain steps may not have been completed (i.e.: "the Suicide Risk assessment was not deemed clinically appropriate because of…"). When the PSC is assessing for SI/HI the client's ideation, plan and timeframe need to be documented in the progress note. The Plan section should consist of PSC and/or client's next steps (i.e.: "Client will be transported by ambulance to SRMH ED for medical clearance to the CSU. PSC to inform treatment team of client's 5150 status and contact CSU staff regarding next steps.").

What should be left out of a progress note? – Think: Less is More

- "Why was this/is this clinically relevant?"
  - It is important to consider the privacy of the client when writing progress notes. If information or details are not relevant to the service provided, then those details should not be included in the progress note.
  - The progress note does not need to be a narrative of the entire session with the client. If the information is not clinically relevant to the client and the client's Mental Health treatment, it does not need to be in the progress note.
  - These are 'Progress Notes', not 'Process Notes'.
    - Progress Notes: "contain only the succinct description of clinically relevant information. Information documented is objective and clinical." (AVATAR Progress Notes – Content & Format; pg. 3)
    - Process Notes: contain "verbatim transcripts…, a clinician's thought process about the client's issues, or a clinician's personal feelings… While details such as these may prove helpful to the clinician in treatment planning and process, they are not needed in the clinical record." (AVATAR Progress Notes – Content & Format; pg. 3)

    - There may be times when more background or a longer narrative are needed in order to contextualize the client's response. The PSC will need to use their clinical expertise of the client, to determine if the information is appropriate.
- Non-Clinical details
    - Try to avoid including non-clinical details that may distract from the client's treatment or progress:
        - For example: "Ali's landlord was very rude to PSC, and was demanding that PSC disclose their relationship to Ali." That information does not add substance to the client's mental health treatment or progress.
- Clients' significant support persons
    - Unless it is absolutely necessary to provide context or to discern one relation from another, specific details about clients' significant supports should not be included in order to protect the privacy of non-clients.
    - Rather than using names (again unless necessary to distinguish one relation from another), clients' significant supports should be labeled by their relationship to the client (i.e.: Mother, Girlfriend, Partner, etc.).

Miscellaneous

- Grammar/Spelling/Language
    - It is important to pay enough attention to grammar and spelling when writing progress notes, so that mistakes aren't distracting from the material or making the note difficult to comprehend.
    - Language used throughout the progress note should be respectful and recovery oriented. Be aware of the use of subjective opinions and judgmental language.
        - For example: "Trish was dressed very provocatively, and was flirtatious with the office staff." Unless this dress and behavior are somehow relevant to the client's mental health treatment, these are the subjective opinions of the staff and should not be included.
    - The note should use the client's identified/preferred name (even if this name does not match their "Medi-Cal" name) and the client's identified gender pronoun (again, even if this does not match their "Medi-Cal" pronouns).
- Travel Time
    - It can be helpful to include where the service was provided within the body of the note, if there is something unusual about the location (i.e.: excessive travel time, a psychiatric hospital, jail, CSU, etc.).
- Substance Use
    - In working with clients, we often engage with them regarding their substance use. It is important to remember that we cannot just treat the substance use disorder. In order for the interventions to be claimable, the primary focus of the

intervention must be to address the functional impairment(s) that is a result of the included mental health diagnosis.
    - For example: “PSC to provide individual rehab services to practice boundary setting (saying no to friend with meth) in order to reduce impairments in social functioning and decision making related to Andy’s diagnosis of PTSD.”
- Generic Notes
    - Progress Notes need to be specific to the specific client and specific intervention or service provided.

When in doubt: check in with your Specialist, Manager or your friendly Utilization Review team (via BHQA@Sonoma-County.org)! We are all here to provide guidance and assistance and to help staff find simple and succinct ways to document the amazing services being provided.