Health Care Agency • Behavorial Health Services • CYS Quality, Review & Training

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Documentation of Interventions-Reminders

Per the California Institute for Mental Health Early and Periodic Screening Diagnosis and Treatment (EPSDT) Chart Documentation Manual (CiMH, September 2007)

Progress Notes for Planned Services need to focus on the **service provided to the client** as a **component of the Client Service Plan.**

The Client Service Plans drives treatment services. Client Plans are to be based on the Assessment and shall include the following elements:

- **Specific, observable, or quantifiable goals tied to the presenting behaviors and DSM IV-TR diagnosis** determined in the Assessment **are consistent** with the diagnoses.
- The types and focus of interventions **will be consistent with the client plan goals**.
- The duration of the interventions.
- The proposed intervention will significantly diminish the impairment, prevent significant deterioration in an important area of life functioning or will **allow the child/youth to progress developmentally as individually appropriate.**

The progress Note for specialty mental health services should document the following:

- Should clearly identify the writer, the client and other persons involved as well as the relation to the client or involvement in the case, **except where rules for confidentiality** would prevent clearly identifying someone in a progress note.
- **Clearly identify the location** of the service activity.
- Avoid **"observational"** or **"narrative"** (i.e., purely descriptive) notes that detail what was observed but **provide no intervention** or **redirection** or **action taken.**
- Summarize and be succinct; **only include details as needed and necessary to convey the goal, the intervention, the client or collaterals response and the follow-up plan** (referred to as a note "standing on its own").

  For example: Therapist processed with client her tired demeanor and flat affects in order to assess the extent of her current depressive symptoms. This resulted in the client expressing feelings of sadness and therapist explored moments during the week where she felt better and happier in order to reframe her negative thoughts. Therapist encouraged client to review and talk about previously discussed activities that she can do to assist her to feel better. Therapist recommended client to do at least one of those activities per day for the next week in order to decrease depressive symptoms.

- Use a standard of documentation that addresses the clinically relevant **service provided as it relates to the treatment goals and objectives of the child/youth** and **the Client Plan**.

- This standard may include, but is not limited to identifying the child/youth's presenting maladaptive behavior or symptom, addressing the assessment or intervention provided

*Reminder: When documenting/writing clinical reports or communications claimed under EPSDT, always **include a copy of the clinical report/communication** in the chart as substantiation or evidence of the task claimed.*

Special Reminders for Case Management and Crisis Intervention Notes

For a **Case Management** progress note, the **intervention must address the situation or reason that consultation, monitoring or linking was necessary.** What is often missing in our case management note is the reason or purpose for this service; and this reason or purpose needs to be connected to the mental health issue identified on the treatment plan. The intervention needs to address this purpose, and demonstrate how the child will benefit from it. To strengthen the note, the plan should include what you will do with the information with any need for follow-up.

For **Crisis** progress notes, the state reimburses us at a higher rate because it **requires immediate assessment, intervention and decision-making/disposition.** In order to bill for crisis, the beginning section of your documentation needs to show the nature of the crisis and the **imminent situation** that requires this type of intervention. Also as a reminder, if you are required to do some non-billable interventions such as waiting for the ambulance, or your client happens to AWOL and the police are required to bring him or her back so you can finish your evaluation, it must be **indicated in the note that MediCal was not billed for** this time.

Include these **three elements** in a crisis note:

- Describe the **imminent situation** (i.e., danger to self/other or gravely disabled);
- Describe the **risk assessment**, Mental Status Exam and Crisis Intervention;
- **Include 5 Axis Diagnosis** with an included primary diagnosis; and the Disposition/Recommendation. (Do not use excluded diagnoses as the primary diagnosis)