Mental Health and SUD **Progress Notes**

Download the PPT from the QM Website:

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May 15, 2025

Meet Your QM TEAM

Betty Ortiz-Gallardo

Claudia Tinoco-Elizondo

Eri Tsujii

Annina Altomari

Mercedes Medal

Caprice Scott

Elaina Acosta Ford

Jessica Zamora

Laurie Bell

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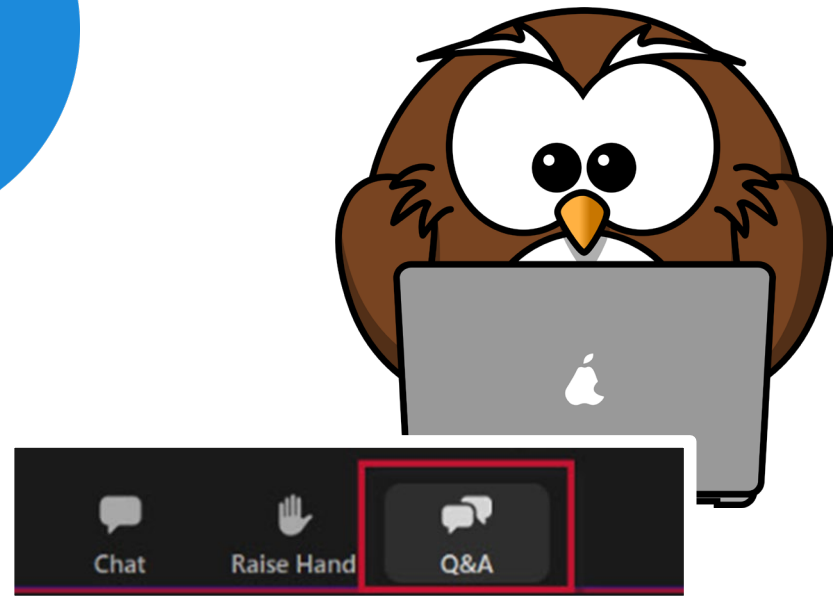
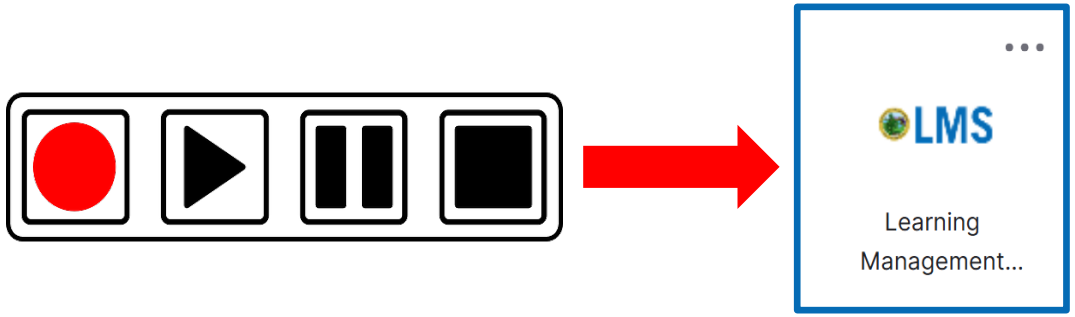
Housekeeping

- Reminder- Please keep your mic muted
- Type your questions using the Q&A button.
- Attendance is tracked automatically in Zoom
- Today's session will be recorded.





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Agenda

At the conclusion of this training, participants will have a better understanding of the following:

- Purpose of a Progress Note
- Timelines for completing Progress Notes
- The difference between a Progress Note and a Process Note
- Key things to consider when writing a Progress Note

Progress Notes

The Basics

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Purpose of Progress Note

Progress Notes

Clinical Record of Client's Treatment

Legal Record

Bill / Claim for Reimbursement

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Purpose of Progress Note

Clinical Record of Client's Treatment

Legal Record

Bill / Claim for Reimbursement

If it isn't documented, it didn't happen!

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When are Progress Notes Due?

Day 0 = The day you provided the actual service

Daily	• Crisis Residential • Adult Residential • DMC-ODS Residential Treatment • Day Treatment services
1 Calendar Day	• Crisis Services
3 Business Days	• All other Progress Notes

For late notes, briefly document the reason for the late note.

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Co-Signatures on Progress Notes

Clinical Trainees ➡ Require Co-Signature from an LPHA for whom the service is within their scope.

Examples of co-signature requirements & who can co-sign:

- ✓ Licensed clinical supervisor co-signing trainee's notes.
- ✓ MD co-signing prescriptions for a resident before the resident is licensed.
- ✓ Co-signing the work of unlicensed staff before the required education or experience for independent recording of services has been acquired.

In some situations, non-Licensed staff may co-sign notes but **ONLY** for the services that are within their scope of practice. For instance, an experienced case manager may co-sign notes for a new case manager, but cannot and should not co-sign notes for a therapist's services.

Registered AOD Counselors, including BHRS staff and contracted providers **require a co-signature on all their progress notes.**

The co-signature must be one of the following identified staff:

- LPHA
- Certified AOD Counselor

BHRS AOD Memo 24-005
October 16, 2024

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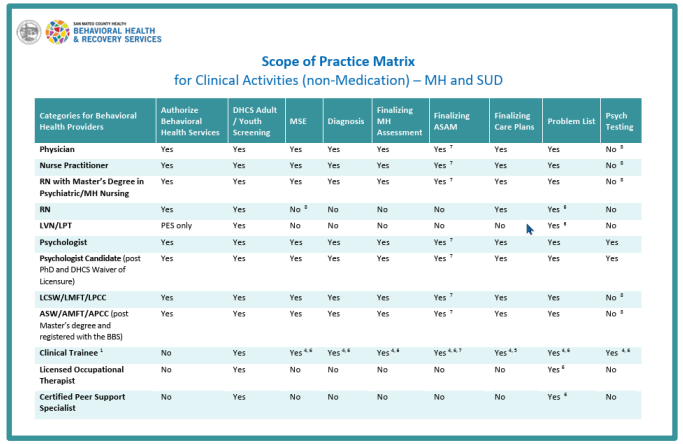
Co-Signatures on Progress Notes

If a service is **not** within your scope of practice under your **job title** and **credential/certification/etc.**, you cannot and should not co-sign progress notes documenting that service.

For example, an Occupational Therapist cannot co-sign an MD's notes.



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Scope of Practice Matrix
for Clinical Activities (non-Medication) – MH and SUD

Categories for Behavioral Health Providers	Authorize Behavioral Health Services	DHCS Adult / Youth Screening	MSE	Diagnosis	Finalizing MH Assessment	Finalizing ASAM	Finalizing Care Plans	Problem List	Psych Testing
Physician	Yes	Yes	Yes	Yes	Yes	Yes [7]	Yes	Yes	No [8]
Nurse Practitioner	Yes	Yes	Yes	Yes	Yes	Yes [7]	Yes	Yes	No [8]
RN with Master's Degree in Psychiatric/MH Nursing	Yes	Yes	Yes	Yes	Yes	Yes [7]	Yes	Yes	No [8]
RN	Yes	Yes	No [3]	No	No	No	Yes	Yes [4]	No
LVN/LPT	PES only	Yes	No	No	No	No	No	Yes [9]	No
Psychologist	Yes	Yes	Yes	Yes	Yes	Yes [7]	Yes	Yes	Yes
Psychologist Candidate (post PhD and DHCS Waiver of Licensure)	Yes	Yes	Yes	Yes	Yes	Yes [7]	Yes	Yes	Yes
LCSW/LMFT/LPCC	Yes	Yes	Yes	Yes	Yes	Yes [7]	Yes	Yes	No [8]
ASW/AMFT/APCC (post Master's degree and registered with the BBS)	Yes	Yes	Yes	Yes	Yes	Yes [7]	Yes	Yes	No [8]
Clinical Trainee [1]	No	Yes	Yes [4,6]	Yes [4,6]	Yes [4,6]	Yes [4,6,7]	Yes [4,5]	Yes [4,6]	Yes [4,6]
Licensed Occupational Therapist	No	Yes	No	No	No	No	No	Yes [4]	No
Certified Peer Support Specialist	No	Yes	No	No	No	No	No	Yes [4]	No

Scope of Practice Matrix for MH and SUD

In some cases, staff can provide a service and document that service in a progress note, but they are not able to finalize the clinical document.

For example, most staff write a progress note coded as assessment and document their efforts to gather information that is within their scope of practice, but not all staff can finalize the actual assessment.

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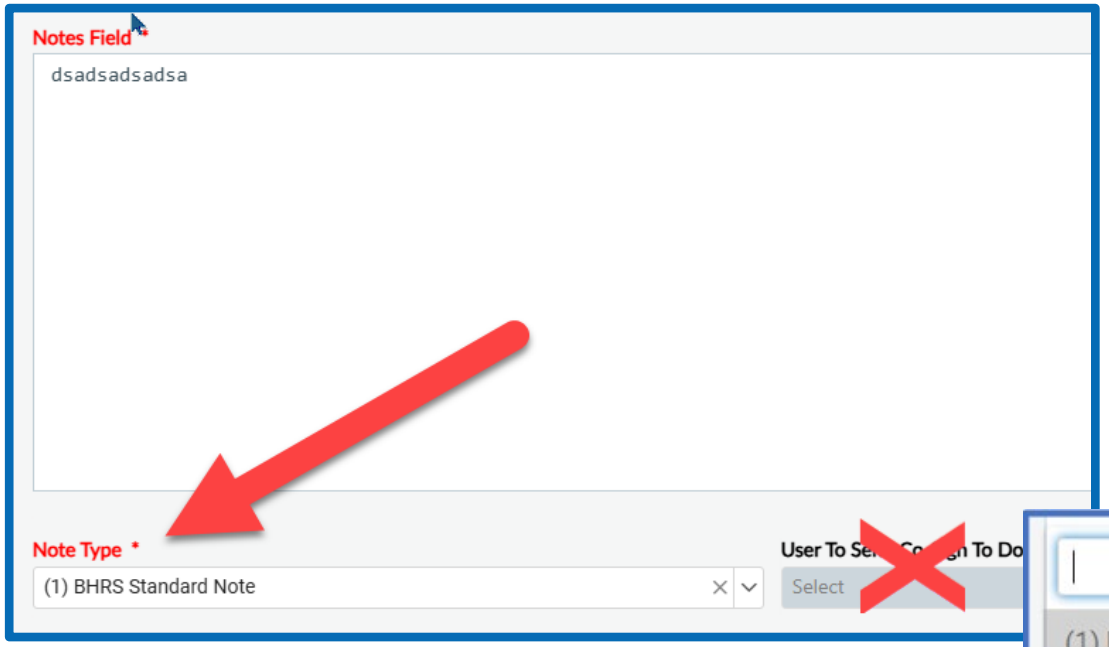
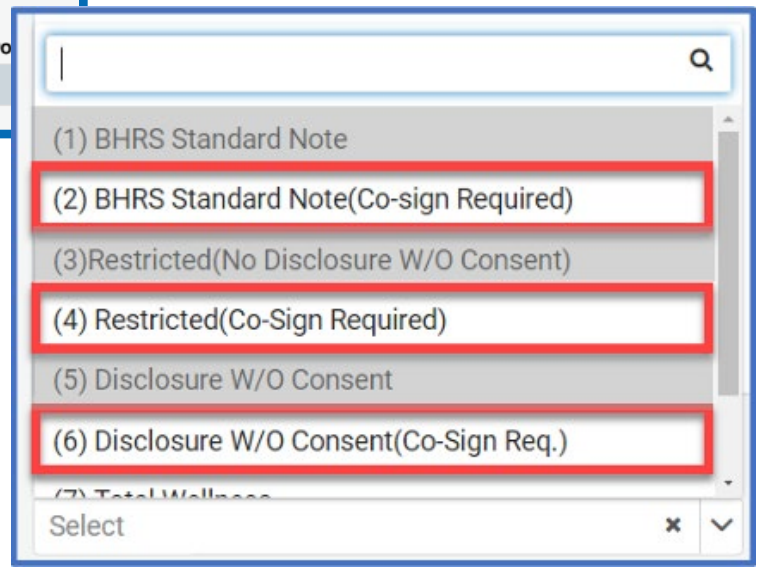
Co-Signatures on Progress Notes





For BHRS Avatar NX users, if you require a co-signature on your notes, be sure to select one of the “Co-Sign Required” options on the “Note Type” drop down menu that is located just under the narrative portion of the Progress Note form.

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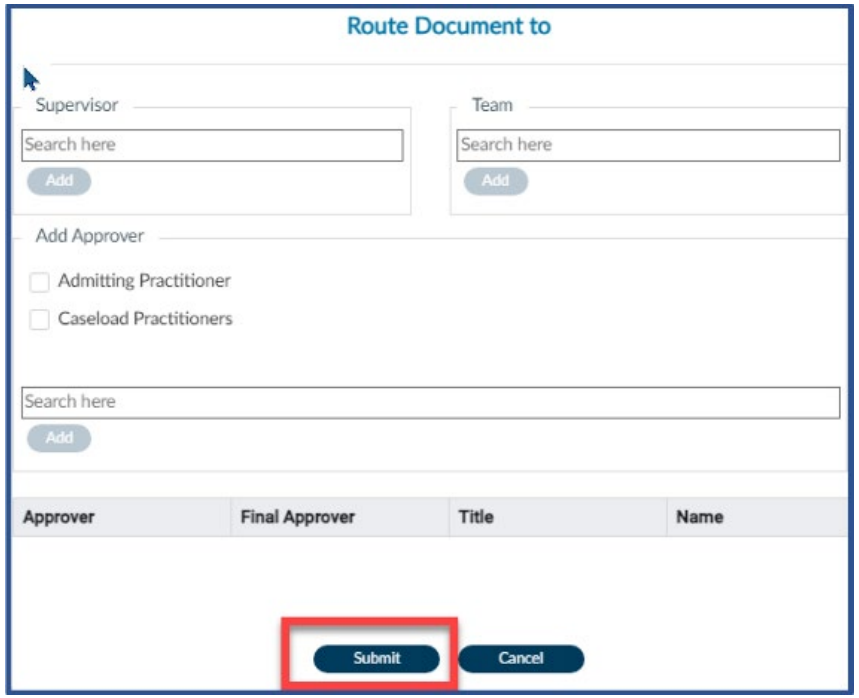
Co-Signatures on Progress Notes



Why does the Document Routing pop-up window show up even if I don't require co-signature?

Due to technical limitations, the Document Routing pop up window shows every time a progress note is finalized regardless of whether a co-signature is required. However, not to worry…if you don't require a co-signature you can easily bypass the window by clicking submit.

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Progress Note
Requirements

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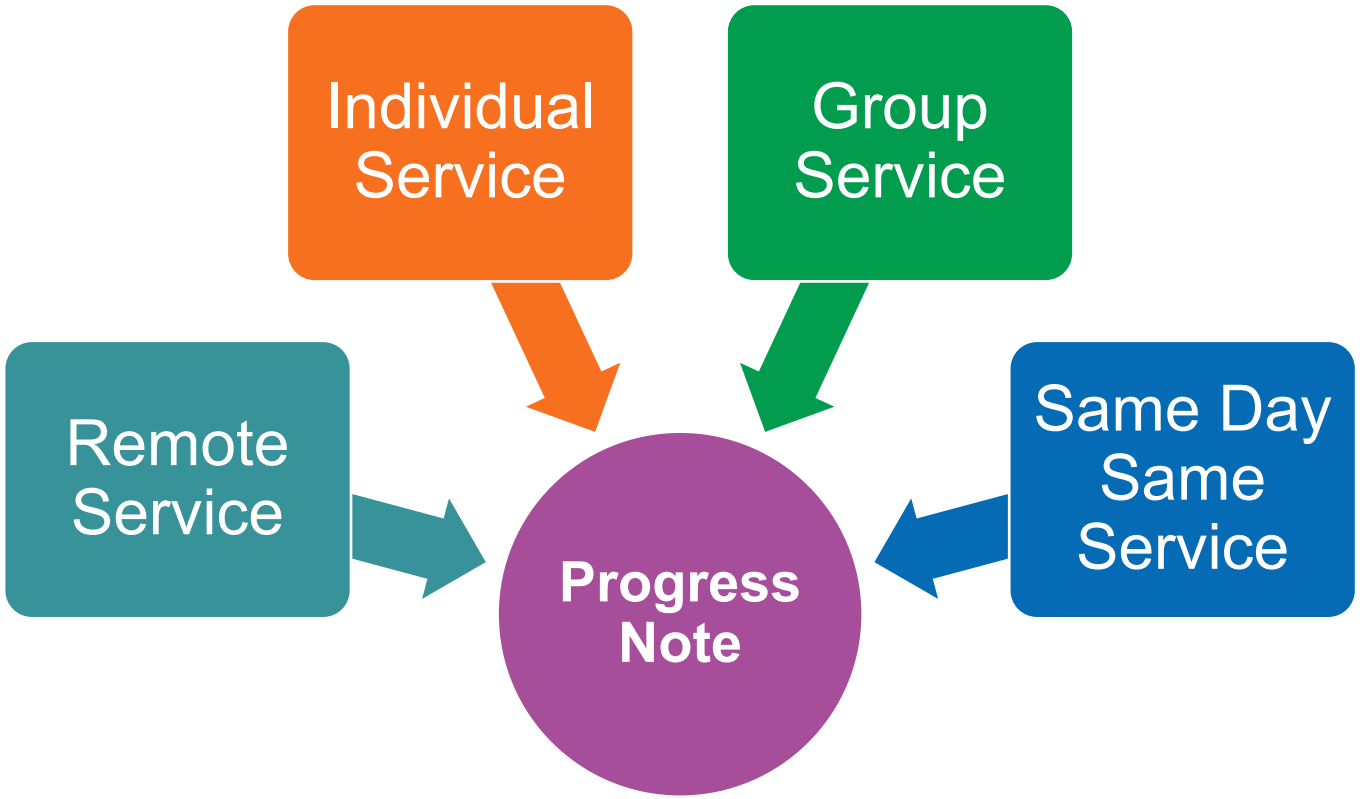
Progress Note Requirements



The minimum required elements for a progress note depends on whether or not you are providing a service:

- Remotely;
- To an individual or to a group; and/or
- Multiple times on the same day to the same client using the same service code.

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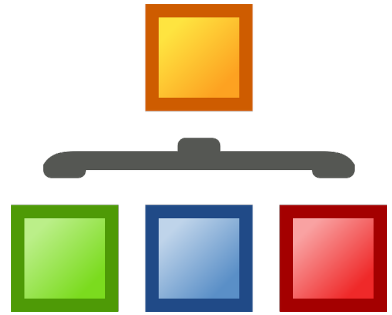
All Progress Notes

All Progress Notes will contain at least the following information:

- Service
- Date
- Duration of Service
- Location
- Provider name, signature, date
- How service addressed behavioral health needs
- Summary of next steps
- Next Appointment



These progress note elements are the foundation of all progress notes.

Some note types require additional information.

- Intervention
- Plan
- Timely Access

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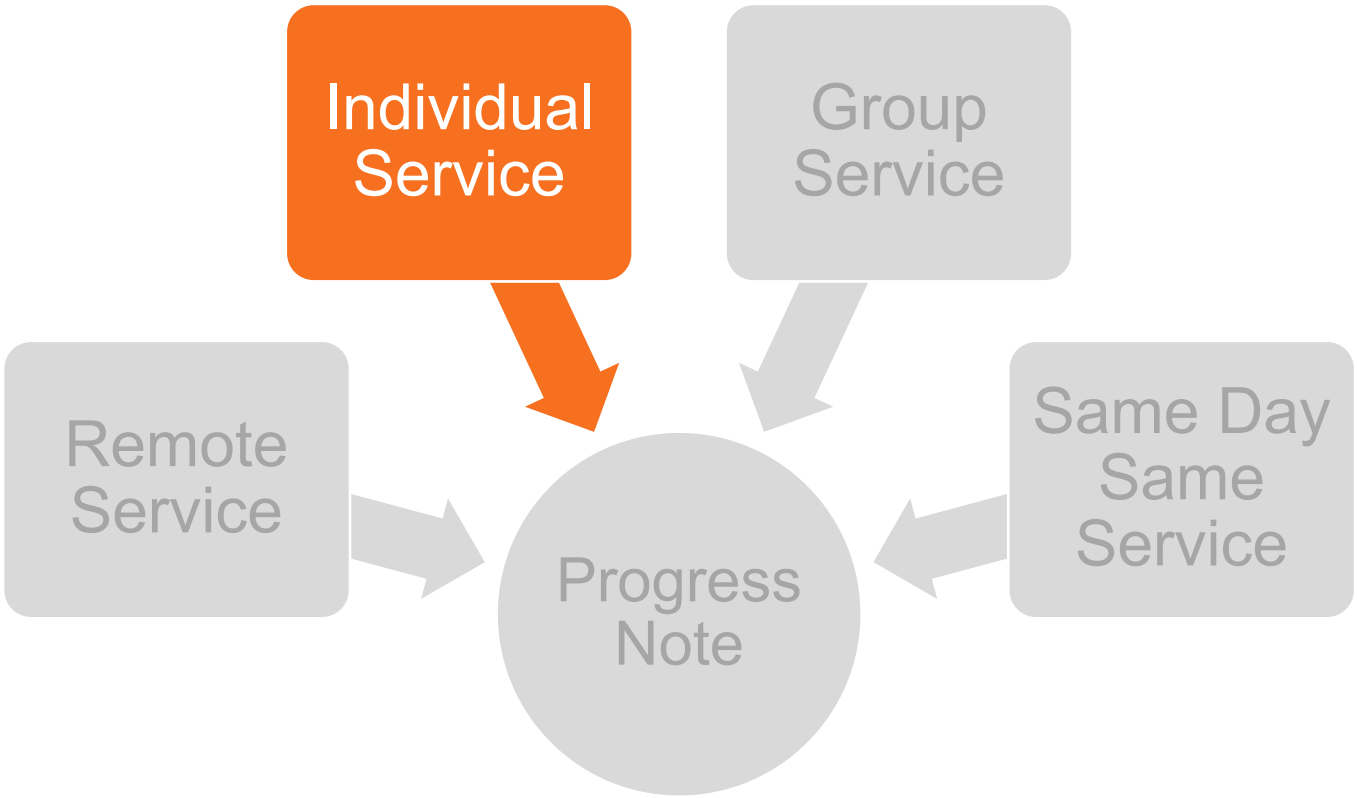
Standard Progress Note



The minimum required elements for progress notes for services provided in-person to an individual (not a group) are the foundational elements for all other progress note types.

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Standard Progress Note

List people involved in the services and their role

- Write out full name, job title, and agency (if external to your agency) of other providers or other professionals who were involved in the service.
- When listing names of other individuals (including collaterals), simply name their role (e.g., client's grandmother)

Service Description

Plan

Next Appointment

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Standard Progress Note

List people involved in the services and their role

This is about the service / intervention provided, **not** the client's response or reaction to the service / intervention provided.

Service Description

Services / Interventions may include:

- Work towards or successful completion of treatment goals and/or barriers to progress.
- Discussion of strengthening coping skills or strategies to improve use of strategies (e.g., increase medication compliance, avoiding triggers, establishing and maintaining healthy relationships, etc.)
- Any EBPs that were used as part of treatment during the session.
- For SUD, be sure to focus on how the service addresses their patterns of use, triggers, etc.

Remember to stay within your scope of your practice.

Standard Progress Note

List people involved in the services and their role

Service Description

Plan

Next steps may…

- be for the client or for the provider
- concern what the provider and client will engage in collaboratively
- concern a collaboration with other providers
- concern a referral
- concern discharge planning

Next Appointment

Standard Progress Note

List people involved in the services and their role

Service Description

Plan

Next Appointment

Providers should…

- Include the date of the **first available appointment offered** to the client
- If the beneficiary declines the first available appointment and accepts an appointment on a later date, also document **the date of the agreed upon appointment**

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Standard Progress Note

List people involved in the services and their role

Service Description

Plan

Next Appointment

Providers should…

- Include the date of the **first available appointment offered** to the client
- If the beneficiary declines the first available appointment and accepts an appointment on a later date, also document **the date of the agreed upon appointment**

Example:

NEXT APPOINMENT:

Clinician offered next available appointment of 9/8/24, however client is not available.

Next appointment is scheduled on 9/10/24.

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Poll 1

The basic element(s) of all progress notes include:

A. Service Type

B. Date, Duration, and Location

C. Intervention

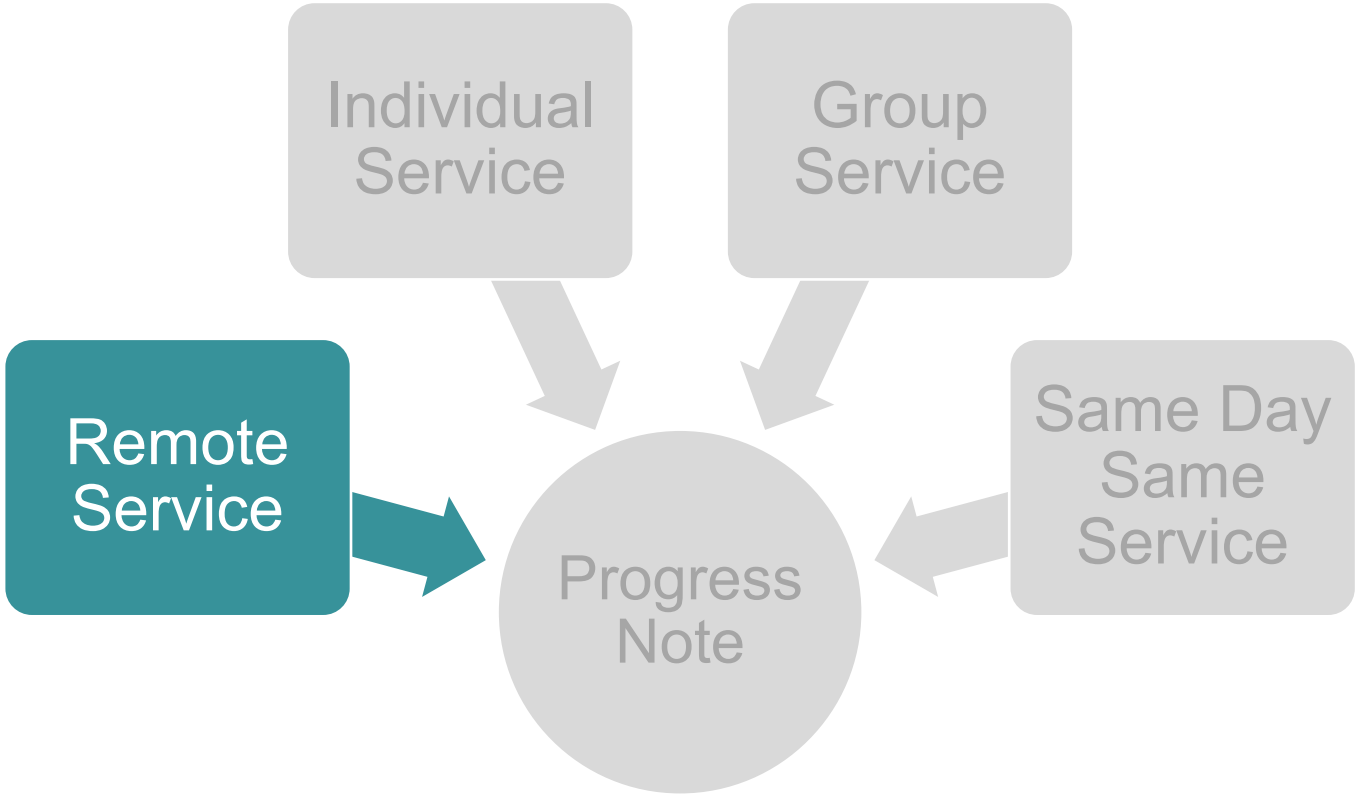
D. Provider Name, Signature, and Date

E. Plan

F. Next Appointment

✓ All of the above

Remotely Delivered Services



There is an additional element if you are providing services remotely:

Location of the client at the time the service was provided.

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Remotely Delivered Services

- Legal requirement that provider **must include the physical location of client at time of the service in progress note.**
- Best practice is to obtain the physical location of the client at the start of each remote session.
- Ensures that a provider can inform first responders/crisis supports of the client's location in case of an emergency.
- Also ensures that the client is located in California. **Remember, we can only provide services to clients if they are located in the State of California.**
- If a client refuses to provide address, document refusal in the progress note.

Division 18 of Title 16 of the California Code of Regulations, which was adopted by the Board of Behavioral Sciences (BBS).

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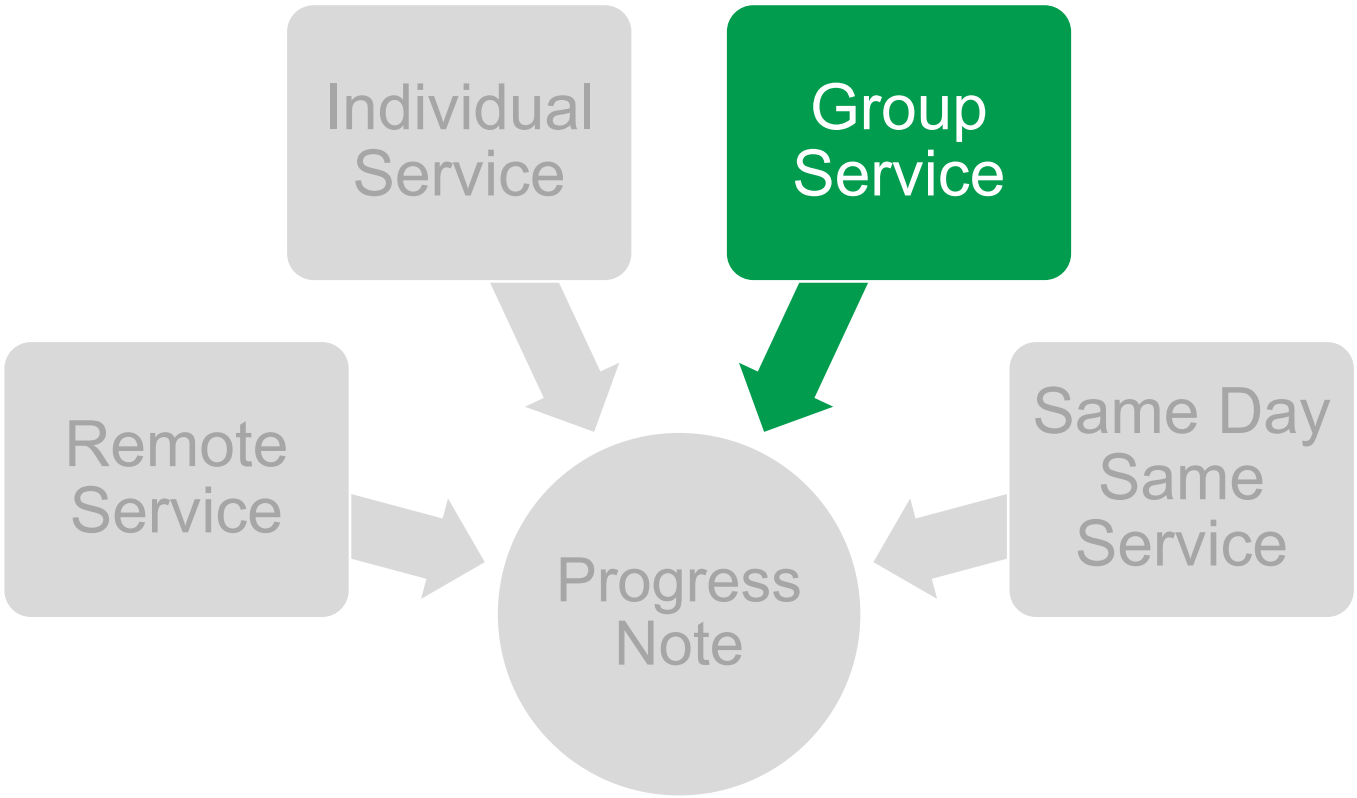
Group Service Notes



Notes for Group Services require 2 additional elements:

1) Client response to intervention
2) If there was more than one facilitator, then a description of your contribution to the group as facilitator.

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Group Service Notes

List people involved in the services and their role:

Facilitator Involvement Description

Service Description

Response to Intervention for Group Services

Additional information required FOR ALL GROUPS:
Describe the **client's response** to the service (e.g., effectiveness of the intervention, progress or barriers, other info relevant to member's participation).

Plan

Next Appointment

Group Service Notes

List people involved in the services and their role:

Facilitator Involvement Description

ONLY COMPLETE THE FOLLOWING PROMPT FOR GROUPS WITH MORE THAN 1 FACILITATOR:
Describe YOUR (1) specific involvement in the group and (2) The specific amount of time of YOUR involvement in the group activity.

Service Description

Response to Intervention for Group Services

Plan

Next Appointment

BHRS Avatar Nx Users - Each Facilitator MUST write their own Progress Note for each group member!

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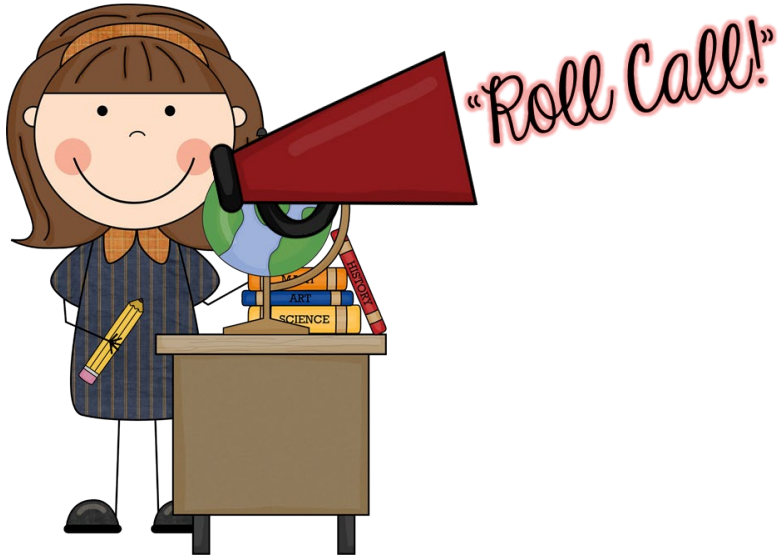
Group Participant List



When a group service is provided, **a list of participants in attendance** for that particular session must be documented and maintained by the provider.

This is also known as an attendance list.

Do not keep a list of group participant names in any individual client's chart.

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Group Membership and Attendance

These might sometimes be the same document.

Group Participant List

A list of all members who attended a particular session.

Sign-In Sheet

Signatures of all members who attended a particular session.

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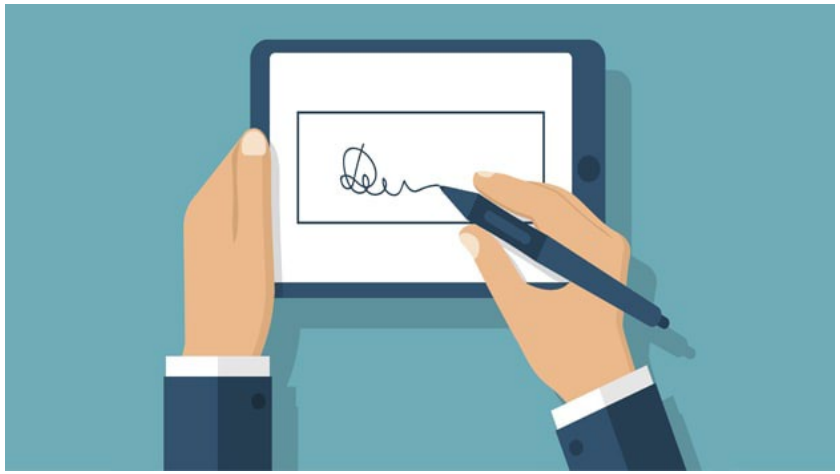
Group Sign In Sheet

Signatures are not required to be included as part of participant lists for MH or SUD groups.

However, Sign-In Sheets should be maintained for group services.

DHCS still requires proof of validation of services rendered, and sign-in sheets are one way to validate that the individual actually received the service that was billed.



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Standard Progress Note

- List people involved in the services and their role
- Location of the client at the time of service
- Facilitator Involvement Description
- Service Description
- Response to Intervention for Group Services
- Plan
- Next Appointment

Poll 2

Which type of service requires a description of the client's response to intervention?

A. Individual (non-group) Services

✓ Group Services

C. All services require inclusion of client's response in the progress note.

Bundled Notes

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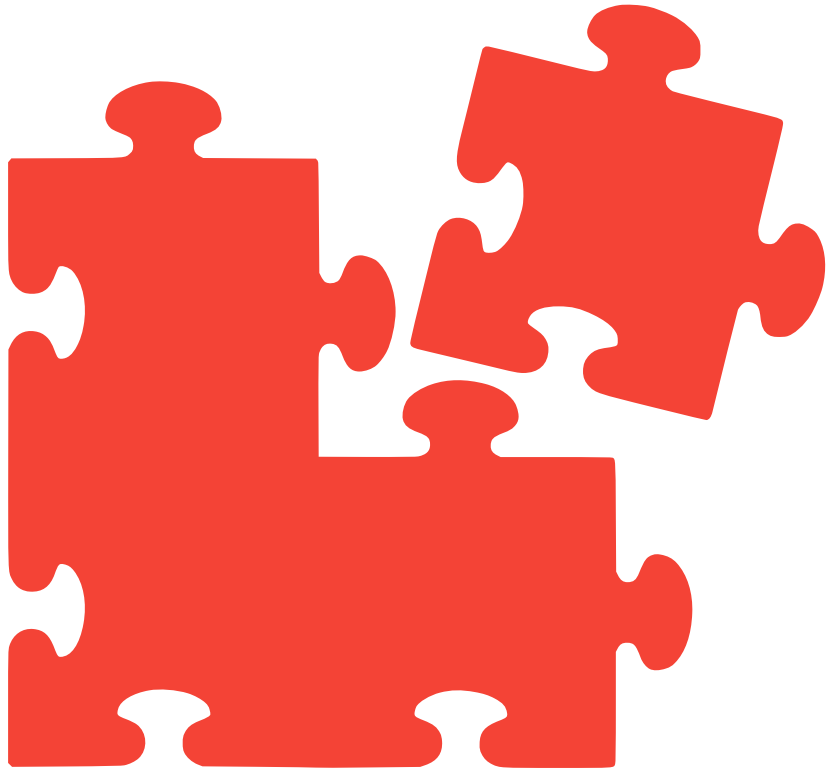
Bundled Notes:

Same Day Same Service



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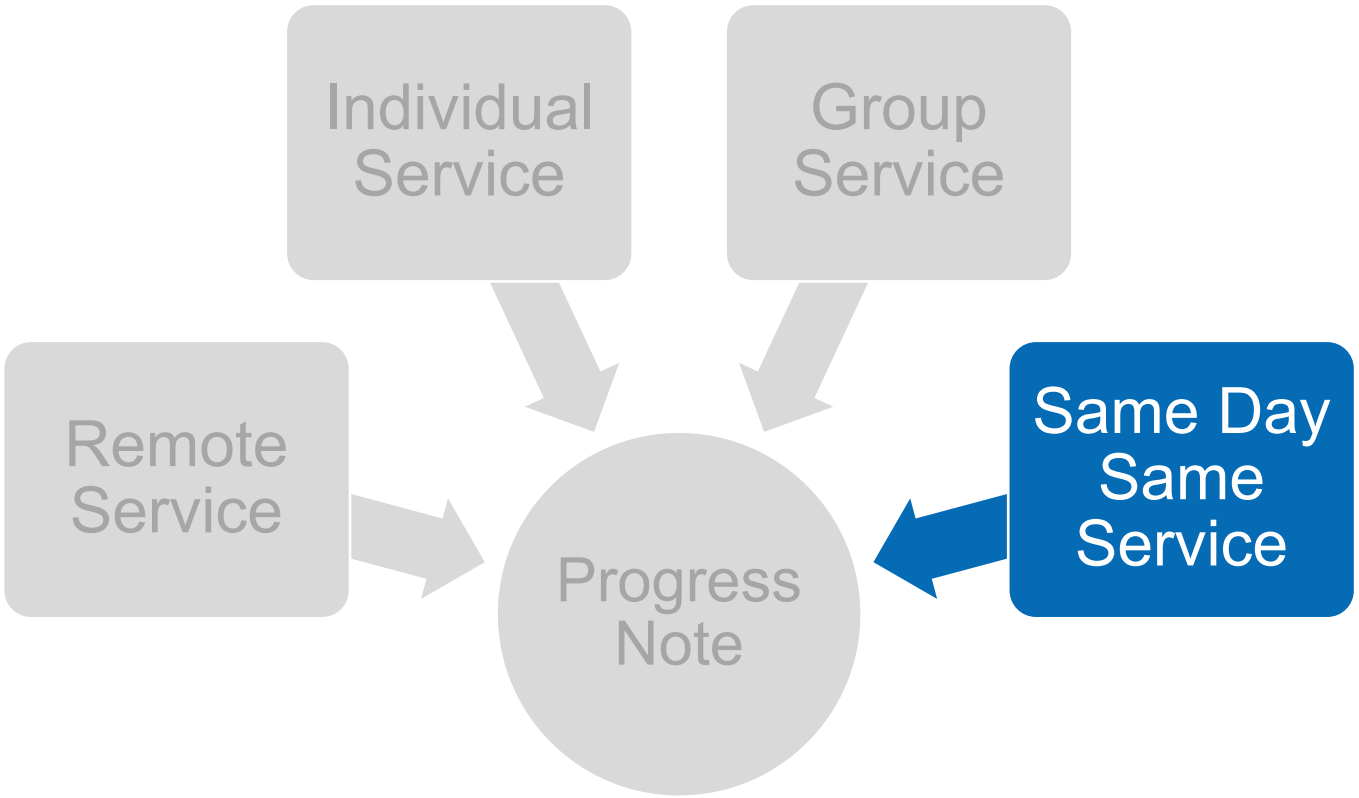
Bundled Notes: Same Day, Same Service Notes



There are no additional elements to Same Day Same Service Notes, but there are rules to follow about when to complete this type of note.

Same Day Same Service Rules **only apply to services delivered to an individual** and does NOT apply to Group Services.

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Bundled Notes: Same Day, Same Service Notes

All claims for *non-group* services delivered to the same client, under the same service code, provided on the same day by the same provider **MUST be combined into 1 Progress Note.**

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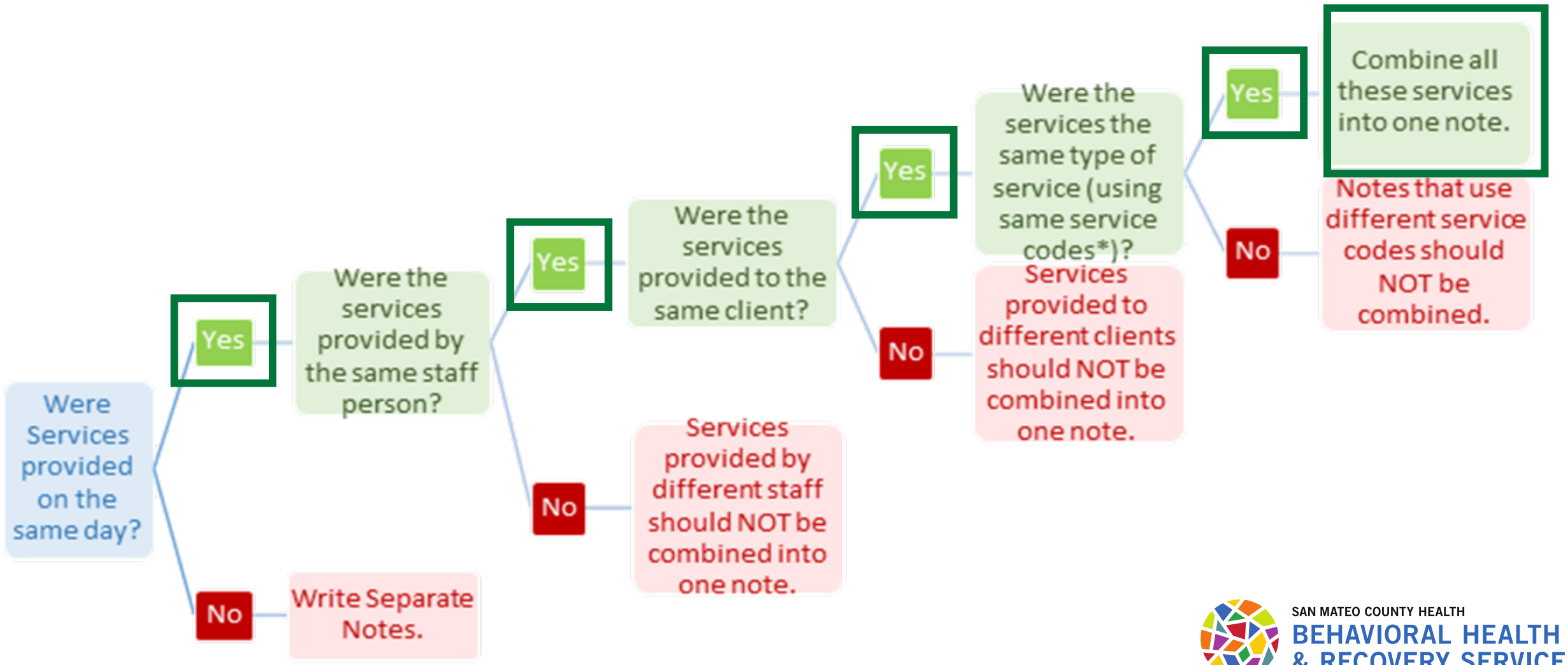
Bundled Notes: Same Day, Same Service Notes



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Bundled Notes:
Daily Notes

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Bundled Notes: Daily Notes

Daily progress notes bundle all services that are included in the daily rate for the program into one Daily Note.

Daily Notes only apply to those programs that bill a daily rate. Therefore, this does NOT apply to outpatient clinic programs, etc.

For information regarding what services are included in the bundled daily rate for your program, contact your Program Supervisor or Program Manager (or AOD Analyst for SUD Contract Providers).

Daily Notes

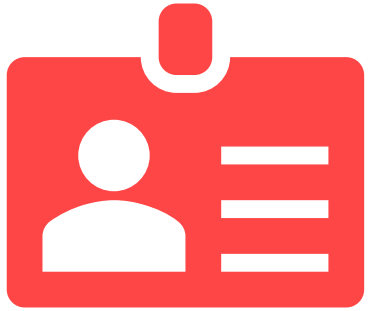
- Crisis Residential
- Adult Residential
- DMC-ODS Residential Treatment
- Day Treatment services

Bundled Notes: Daily Notes

Same Day, Same Service Notes do not apply to services that are documented in a Daily Progress Note.

Unlike Same Day, Same Service notes, Daily notes may include different types of services delivered by different providers. Remember to include the full name and credential of the staff that provided each service that is included in the daily note.

Daily notes must be signed by the individual overseeing all of the services included in the daily note.



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Bundled Notes: Daily Notes

Additional services that are provided **outside of the bundled services** should be documented using the Same Day, Same Note process.

Example: If Case Management (MH) / Care Coordination (SUD) is not part of the residential bundled rate for your program, you would document the CM/CC service in a separate progress note (not in the Daily Note) AND use the Same Date Same Note rules for all CM/CC services provided that day.

For DMC-ODS Residential Treatment Services…

Care Coordination and Recovery Services Are the only two services that can and should be billed in a separate progress note outside the bundled service.

Poll 3

Pick the accurate statement:

A. Daily Notes are required by programs that bill a daily rate

B. Same Day Same Service notes are required for services that are not included in a daily bundled rate.

C. Same Day Same Service notes should be completed by all programs that do not bill a daily rate.

D. B and C

✓ A, B, and C

Bundled Notes:

Additional Guidelines

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Bundled Notes: Consider Workflow

When should I write my Progress Notes?

Throughout the Day BUT Finalize at End of Day

End of Day

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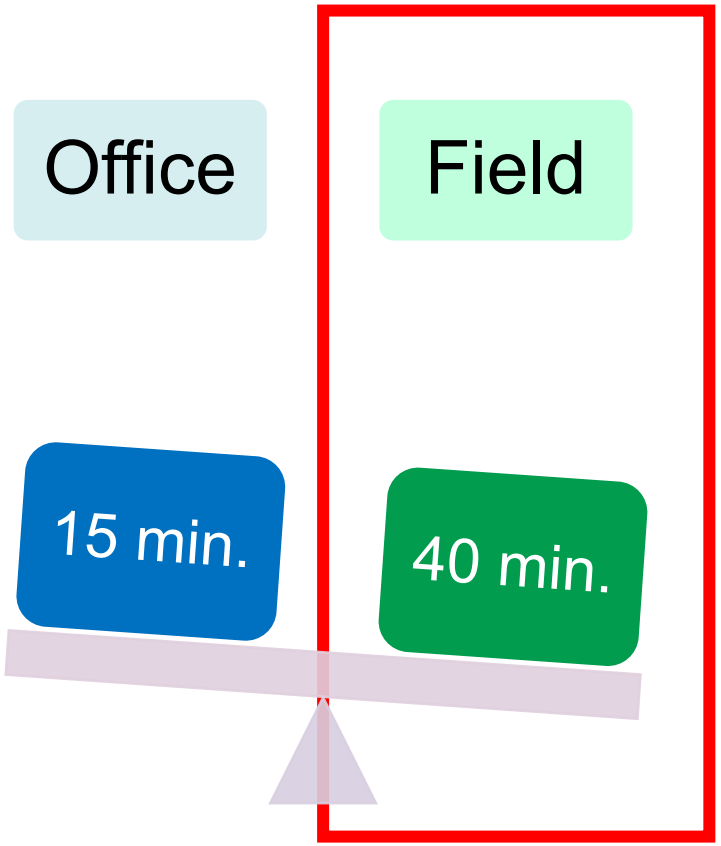
Bundled Notes: Multiple Locations



Pick the longer of the services and use that Location Code

What if the service took place in multiple locations?

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Bundled Notes: Multiple Locations

Example

Scenario:

19-year-old client was recently kicked out of their shared apartment by his roommates for not paying rent. Client is staying at his aunt's home and needs help finding an affordable place to live.

You met with the client this morning in person at his aunts home for 40 min to discuss housing.

then contacted a housing program this afternoon via video conference for 10 min,

then called the client who was at home to let them know the outcome of the call and discuss any additional supports needed for 15 min

1 **First Service**

Location = Home

2 **Second Service**

Location = Phone **Non-Client Contact**

3 **Third Service**

Location = Phone **Client At Home**

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Same Day, Same Service, Multiple Locations

For Mental Health Staff

For SUD Staff

Instructions for logging time is the same for SUD and MH staff.

Service Code	**MH Service Coding Case Management** (51CA)	**SUD Service Coding Care Coordination** (AD113ODSCM_CA)	All services in this scenario fall under Case Management for MH Staff and Care Coordination for SUD Staff.
Service Time	65 minutes	65 minutes	Time of all Case Management Services combined
Documentation Time	12 minutes	12 minutes	Total time to document all services
Travel Time	36	36	Round trip from usual worksite to client's home
Location	Home	Home	You saw the client at home for the majority of the time.

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Same Day, Same Service, Multiple Locations

List people involved in the services and their role

This Clinician, Client, Home Sweet Home Housing program coordinator Rose Smith

Location of the client at the time of service

Staying with aunt at 1234 Main Street, Redwood City

Service Description

Clinician met with client at his aunt's home and spoke to client about immediate housing needs after client was kicked out of shared apartment by roommate for lack of payment. Client is staying with his aunt for a few weeks and then will need housing. Clinician contacted Home Sweet Home program via phone. Program Coordinator explained referral process and next steps in order for client to be placed in housing unit. Clinician completed referral and ROI between BHRS and Home Sweet Home (see referral and ROI dated 9/3/24). Clinician contacted client back to explain next steps and evaluate additional supports needed via phone.

Plan

Client is to attend appointment with Home Sweet Home on 9/5/24 for placement assistance. Clinician will follow up with Program Coordinator to communicate additional supports needed such as food and clothing resources.

Next Appointment

Client offered next appointment of 9/8/24 but not available. Next appointment confirmed for 9/10/24.

Progress Note Templates

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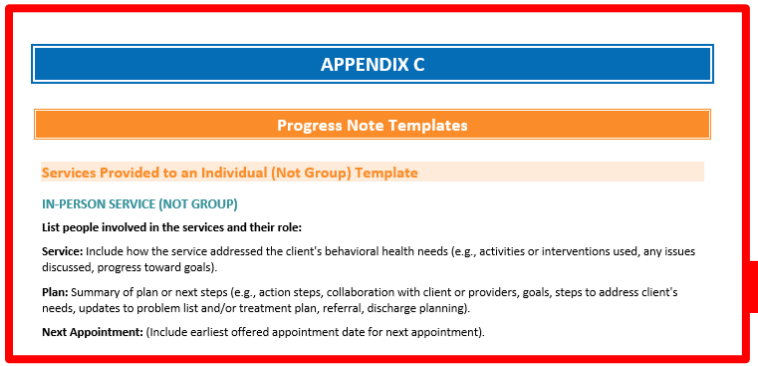
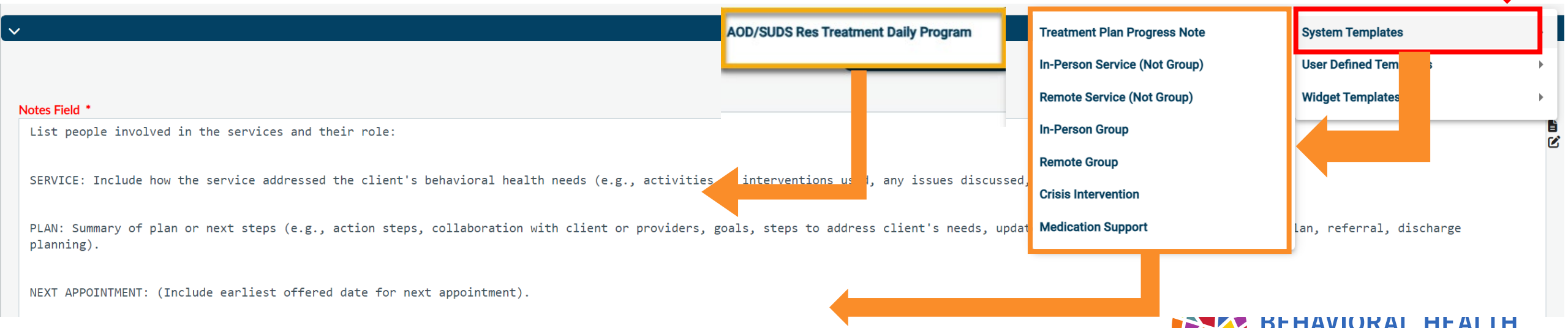
Progress Note Templates

The use of templates is NOT required but is available for those who find them helpful.

For those who would like to use templates to help them write their progress notes, Progress Note Templates are now available in **Appendix C** of the **BHRS Documentation Manual for SMHS**.

BHRS SUD currently only uses the “AOD/SUDS” Res Treatment Daily Program” Template





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A Note about Response to Interventions

- **Not required does not mean not allowed.** Even if a progress note template doesn't include a response section, you may still include this information.
- Times when it may be appropriate to add response to intervention for individual service notes:
  - How did the client respond to crisis intervention and what next steps or safety plan was determined based on their response?
  - It's important for SUD Progress Notes to include: what were the client's responses to relapse prevention, motivational interviewing, or supportive coaching?
  - Use your clinical judgment to determine when it is clinically appropriate and necessary to include response to intervention.

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Progress Note Templates

DHCS guidelines include what is needed at minimum to bill Medi-Cal. If you find that using other formats such as a SOAP or BIRP format are helpful in writing notes, feel free to use them. **Just make sure to include the minimum required elements** from the templates we have provided to meet DHCS Medi-Cal requirements.

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Poll 4

You **must** use the progress note templates and cannot add or remove any information that is not specified in the template.

A. True

B. False – You can exclude anything that is in the existing template if it is clinically appropriate to do so.

False – You do not have to use the template if you include at least the minimum requirements for a Med-Cal progress note.

Progress Note Narrative

Do’s and Don’ts

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Important Considerations

Access to a client's chart may be requested for reasons including, but not limited to…

Clinical Record	Billing / Claiming	Legal Record
• Client or Client's LAR • Other providers	• Client or Client's LAR • Other providers • Insurance • Auditors	• Client or Client's LAR • Client's attorney • Other party's attorney • Court

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Important Considerations

In the future, clients will be able to easily access their chart, including progress notes, in real time via a patient portal. When exactly this will happen is TBD, but notes written prior to the launch date will likely be included.

Establish care with the individual.

Provider documents in the chart.

Client or LAR accesses chart via the patient portal!

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Important Considerations

Because a variety of people potentially have the right to access the chart for different purposes, **it is important to only include the minimum necessary** to bill for Medi-Cal, document the service, and any other pertinent clinical information.

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Important Considerations

I don't want my client to see the chart because I think it will demotivate them or make them think badly of themselves…

Strength-based documentation can

- help you feel comfortable with sharing your notes with your client,
- help your client feel hopeful and not defeated if they read the chart,
- Includes respectful, person-based language that reflects your own respect and care for the client and avoids the use of stigmatizing language.

Important Considerations

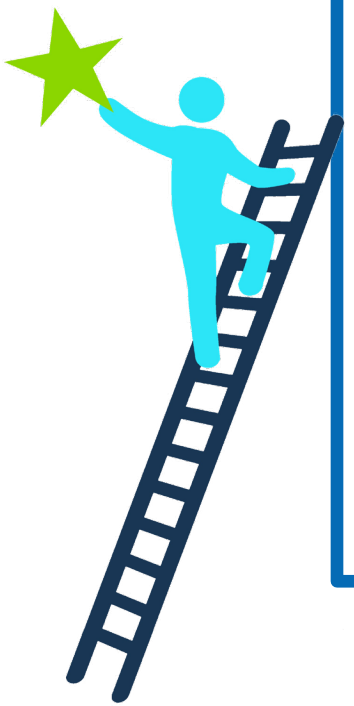
Strength-based documentation does NOT mean that you only focus on the client's strengths or only write about the positive progress the client has made.

Deficit-Based / Stigmatizing Language		Strength-Based Language	
"Entitled"	Implies that they are not deserving.	"Advocates for their rights"	Explains the behavior rather than stigmatizing them for doing so.
"Substance User" "Schizophrenic"	Implies that this is the core/main aspect of their identity.	"…who is experiencing symptoms related to…"	Explains their functioning / challenges as it relates to the focus of your treatment.
"Non-Compliant"	Implies that the client is someone who needs to be told what to do and that they are not interested in improving their functioning.	"…is currently preferring to use alternative coping strategies such as x, y, and z"	Explains the client's behaviors in the context of behaviors they are engaging in. Leaves the door open for their engagement in treatment process.
"Client's house was a mess."	Implies a judgment on the client's living situation.	"…has struggled with his goal of keeping his house organized."	Explains the state of the client's home in the context of client's treatment goals.

Important Considerations

One more reason to be more objective in the notes by including not just the strengths but also the client's struggles…

If a client needs to share their records in order to, for instance, receive specific services / benefits, if the chart doesn't reflect their challenges, then it may jeopardize the argument that they require or qualify for more benefits/services.



Ready to Step Down?

If you have notes that only describe how well the client is doing AND it's been a while of this type of improvement-only content, consider if the client has met their goals and is ready to step down to a lower level of care.

Important Considerations

What should I do about documenting sensitive information such as immigration status, abortion history, etc.?

- Follow the same rule that applies to all progress notes: Only write the **Minimum Necessary**
- You are **NOT** writing the client's memoir or writing a play-by-play of the session or writing detailed notes about the source of their personal struggles.
- You **ARE** documenting your intervention (and for group services how the client responded).
- If you must note the cause of their distress, struggles, etc. then write the **minimum necessary** such as "client is experiencing a difficult life transition" or "client recently moved to the area" or "client had panic attack due to concerns about a medical procedure."

Remember, restricting a note does not mean it can never be shared. There are circumstances in which a restricted note still has to be shared if there is no legal argument not to.

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Poll 5

How should you document sensitive information a client shared in session?

A. Document everything in detail. Since it falls under HIPAA the client doesn't have to worry about it ever being shared.

✓ Document only the minimum necessary as it pertains to the treatment/intervention.

C. Document nothing and write a 55 note saying the session was missed. Better to be safe than sorry!

Tips for Writing Progress Notes

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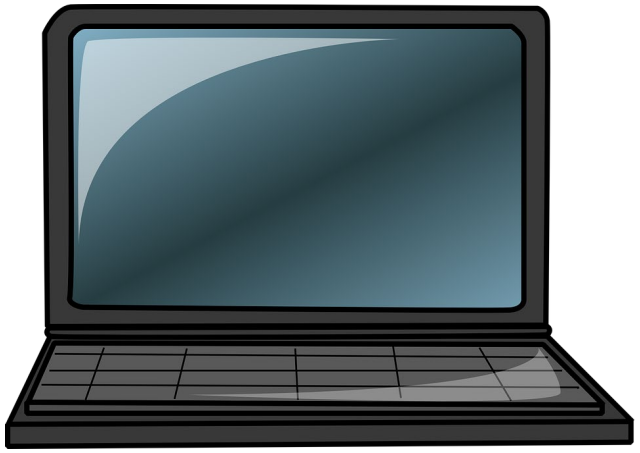
Progress Note Tips



Progress Notes

- These are the notes that get entered into the EHR and become a legal part of the client's medical record.

Process Notes

- These do NOT get entered into the EHR.
- Mental Health = "Psychotherapy Notes"
- SUD = "SUD Counselor Notes"

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Progress Note Tips

Progress Note ✓

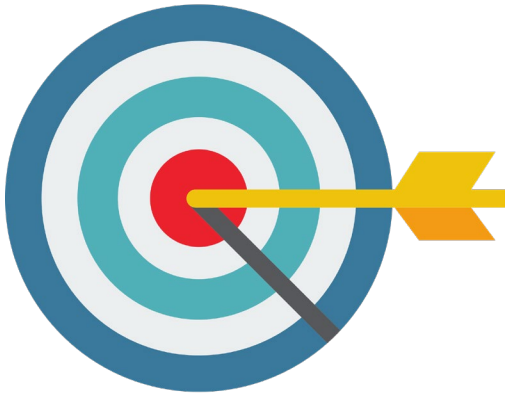
- Persons involved (**do not include names of non-beneficiaries** in the note).
- Interventions used.
- Plan for next steps.
- If beneficiary response is included, this should be **brief and what is minimally necessary**. Do not include speculation, opinions, etc. If noting statements a beneficiary made in session, it is better to quote the beneficiary directly rather than summarize or interpret the beneficiary's words in the note.

Process Note ✖

- Detailed narrative of what happened in session.
- Provider's opinion/analysis of beneficiary's behaviors/symptoms in session.
- Provider's reflections on countertransference, etc.
- Speculation regarding what transpired in session.

Progress Note Tips

- **Focus the content of the note on your interventions / service provided** (in the case of group services, also include the client's response to your interventions).
- **Be objective.** Don't insert your opinions or a detailed description of your internal analysis of your client.
- If something occurred that trigged your client by another individual, such as another client's behaviors in a group session, you may write a brief statement about the trigger. But remember… **Minimum Necessary.**



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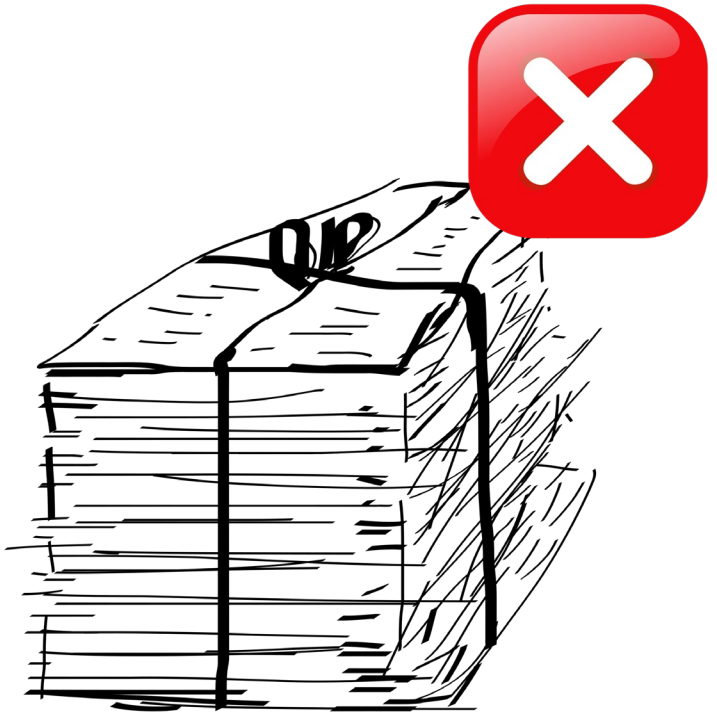
Progress Note Tips

When describing what happened in session…Do NOT do this:

Writer met with client. Client talked about his day and said that he was frustrated with his mother. Client talked about how his mother is “always on his case.” Client was agitated and was breathing heavily and face was red. Writer asked client clarifying questions about what he means by “always on his case.” Client stated that his mother asks endless questions about how he spent his time, who he spent time with, etc. Writer explored with client possible reasons for why his mother might be doing this. Client identified things in his past that have happened that might have led mother to be concerned about his ability to make safe and appropriate decisions. Client reported “Like the time I got high and took her car without permission and drove to a friends house down the street when I didn’t have a license.” Client stated that he has matured since things like that happened a few years ago and is frustrated that mother doesn’t see the change. Client calmed down as session went on. Writer discussed with client….



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Progress Note Tips

When describing what happened in session…DO this:

Writer and client met for individual session. Writer engaged in reflective listening and explored with client root of his ongoing struggles with having positive interactions with his mother. Writer assisted client in identifying specific feelings, thoughts, and assumptions client has that contributes to his frustrations. Writer coached client on CBT techniques to reframe thoughts to reduce frustration.

Poll 6

When writing a Progress Note that gets entered into the client's medical record, it is important to remember:

A. To include your analysis and speculation about the client's behaviors so that you can justify your intervention and next steps.

✓ To include an objective description of your intervention.

C. To include full names of non-professionals who were referenced in the progress note.

Additional Confidentiality Considerations

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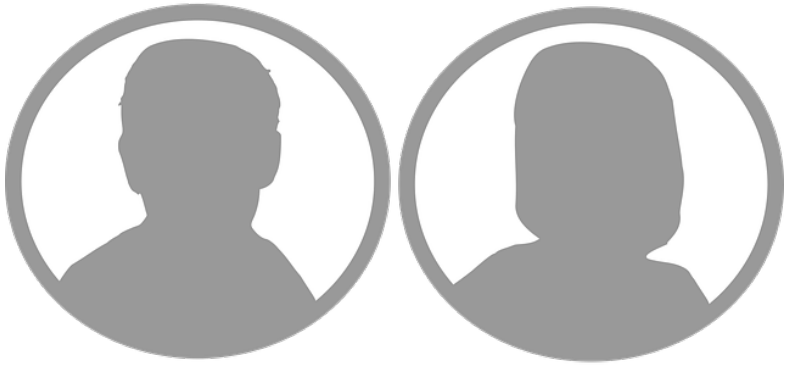
Confidentiality in Progress Notes

Don't write another person's name in a client's chart
unless it is another provider or other professional.

- This includes names of other clients with whom your client interacts (e.g., clients in the same therapy group).



What should I do if I need to mention another non-professional person in my client's chart?

- Refer to the relationship - mother, husband or friend. Do not use names.
- Use initials when needed for clarification.

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Confidentiality in Progress Notes

Also remember to:

- **Limit what you say** about family members because you are documenting in the client's chart, not the family member's chart.
- Use "**as reported by**" or another similar phrase if reporting something someone else said.
- **Minimum Necessary**

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Important Considerations

SUD Programs that fall under 42 CFR Part 2 have much stricter privacy rules than HIPAA. Therefore, for those who use BHRS Avatar …

- BHRS SUD client charts (including Progress Notes) can only be seen by that specific SUD Program.
- Other SUD Programs cannot view the client chart that are part of another SUD program.
- Mental Health Programs cannot view any client charts from an SUD program.

Changes to 42 CFR Part 2 will be coming in 2026. Current policies will be updated and training will be provided regarding the updated regulations.

SUD Records

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Confidentiality in Progress Notes

Special Note about Sessions that result in Incident Reports

- Anything out of ordinary in either an individual or a group session – If needed, write an incident report.
- Do NOT mention that you made an incident report in the progress note.
- Do NOT scan IR into chart.

For more information on Incident Reporting see Policy 93-11.

Incident Reports do NOT belong in a client's chart.

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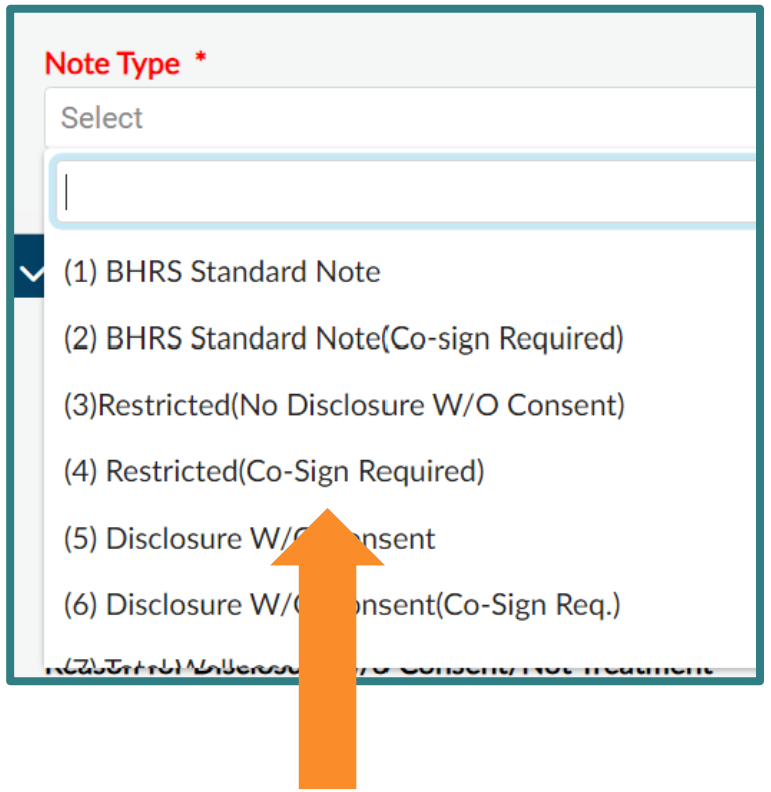
Confidentiality in Progress Notes… Restricted

BHRS Avatar NX WILL NOT hide these Progress Notes.

Other providers can still see Restricted Notes.

Restricting a Progress Note flags the note as Restricted and it is intended to signal the provider to **review the note prior to releasing it to determine if an ROI is needed to release the specific info.**



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Confidentiality in Progress Notes… Restricted

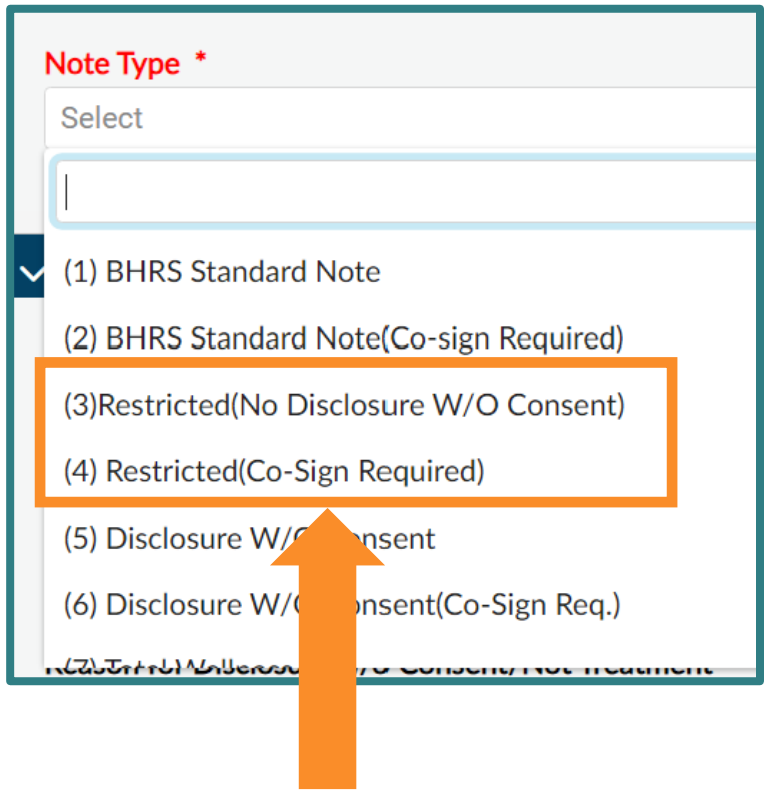
All notes should be reviewed prior to release, but restricted notes indicate that a higher level of scrutiny should be applied when reviewing the restricted note.

Restricted (No Disclosure W/O Consent)

- Should not be disclosed without an ROI from the client.

Examples of when to use:

- *Notes that contain info about HIV status*
- *A youth client requests specific info to be restricted – such as sexual behavior (not abuse), AOD use/treatment, HIV fears and other private or personal info. Use Caution.*



Those staff who require a co-signature should select Option 4 (Co-sign required).

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Important Considerations

DO's

- ✓ Write as if an attorney and/or the client/family will read the note
- ✓ Be prepared to defend every statement
- ✓ Stay objective and respectful
- ✓ Use person-centered language
- ✓ Use templates

DON'Ts

- ✖ Use clinical jargon, terminology or abbreviations that aren't widely recognized
- ✖ Write a lengthy narrative
- ✖ Use stigmatizing language
- ✖ Write a play-by-play of what happened in session.
- ✖ Write your personal opinions

If it's not documented in writing, it didn't happen!

Poll 7

True or False:

As long as I flag my notes as “restricted” I don’t have to worry too much about anyone seeing the progress notes I write, including my client.

A. True

✓ False

Additional Progress Note Fields

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Progress Note Fields

Enter time traveled in **Travel Time** field in Progress Note

- ✓ **From your usual worksite to:**
  - another County site to provide a billable service
  - a community location to provide a billable service
  - a beneficiary's home to provide a billable service
- ✓ **Travel between multiple clinics** in a day to provide billable services.
- ✓ **Missed Visit/no show** = Include Travel Time and use Location Code “Missed Visit”

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Progress Note Fields

Do **NOT** include in Travel Time field.

- ✖ Personal residence to your usual worksite.*
- ✖ Your usual worksite to your personal residence at the end of your workday.*
- ✖ Traveling for administrative tasks related to a specific client's care = Not Travel Time. Instead, add to Other Non-billable.

** The only time you can include in the progress note is the time equivalent to going to/from your office site to the site of service. Any time that exceeds that would not be included in any time fields in the progress note.*

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Progress Note Tips

APPENDIX A

Service Code, Location Code, Time Field Matrix

Entering Time for Reimbursable vs Non-Reimbursable Services.

	Billable (Reimbursable) Service Code	55 or 550 Service Code	Lockout Location Code	Missed Visit* Location Code
Service Time	Use for time spent providing direct service to the beneficiary, collateral, or case management services with other providers.	Use for time spent providing the actual service.	Use for time spent providing the actual service.	Zero because no service was provided.
Documentation Time	Use for time spent on documentation related to writing the progress note, assessment, treatment plan, or other clinical documentation.	Use for time spent documenting note.	Use for time spent on documentation related to writing the progress note, assessment, treatment plan, or other clinical documentation.	Use for time spent documenting note.
Travel Time**	Use for time spent traveling to/from the appointment.**	Use for time spent traveling to/from the appointment.**	Use for time spent traveling to/from the appointment.**	Use for time spent traveling to/from the appointment.**
Non-Billable Time***	Use if a non-billable service was provided during this appointment.	N/A	Use if a non-billable service was provided during this appointment.	Use if a non-billable service was provided during this appointment.

SUD uses Code AD 80

For additional guidance on how to document travel and documentation time, please refer to Appendix A of the BHRS Documentation Manual for SMHS.

SUD providers may also use the information in Appendix A as the same guidance applies for SUD service documentation.

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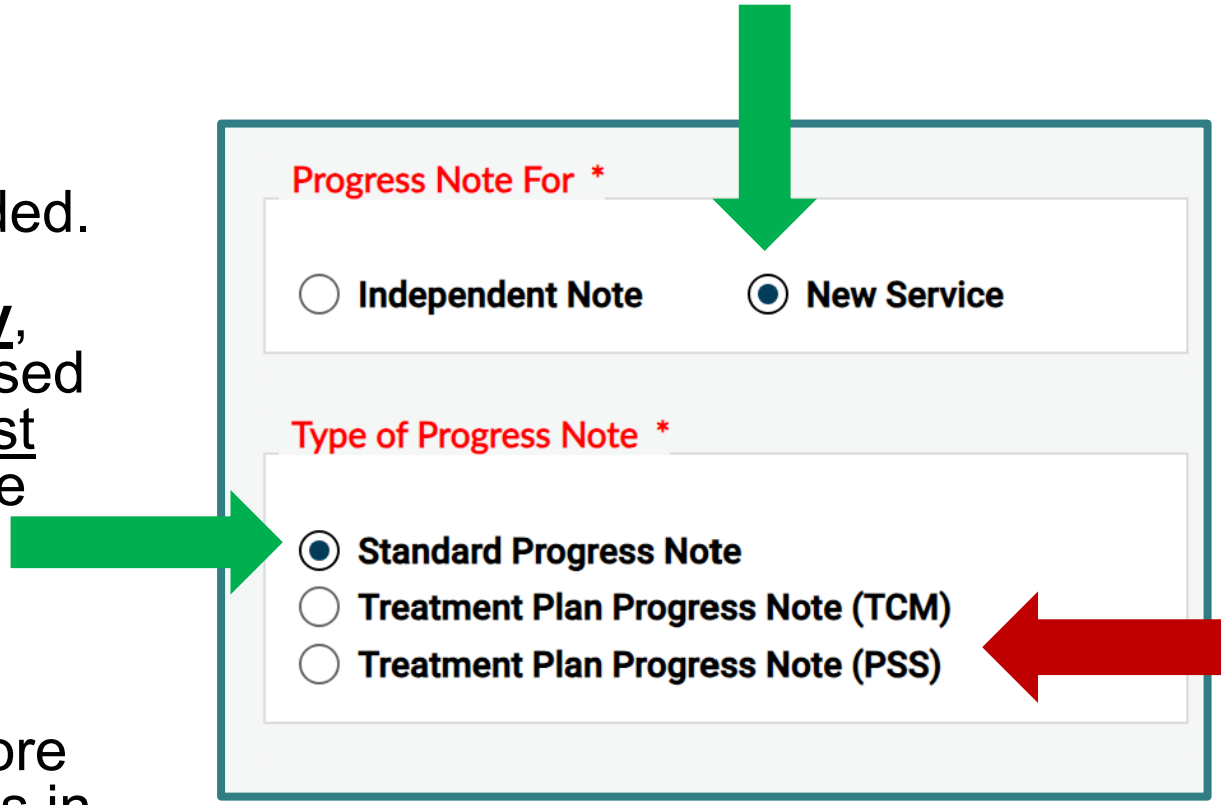
Progress Note Fields

Progress Note For…

- In most cases, you should select "**New Service**" to document a service you provided.
- An "Independent Note" is used **very rarely**, usually for documenting an event for a closed client. These do not get billed and you must write the date and duration of service in the body of the note.



Type of Progress Note

- **Do not** use Tx Plan Progress Note yet! More to come on Treatment Plan Progress Notes in a future training!
- For now, please only use the "**Standard Progress Note**."

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Final Words

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Progress Notes

- Purpose includes: payment and legal and to promote good clinical care.
- Read your last progress notes before meeting with your client to refresh your memory and know what to discuss.
- Refer to your previous progress note entries for continuity.

- Document your notes as soon as possible after each session so you don't forget any important details.
- Remember: **Minimum Necessary!**

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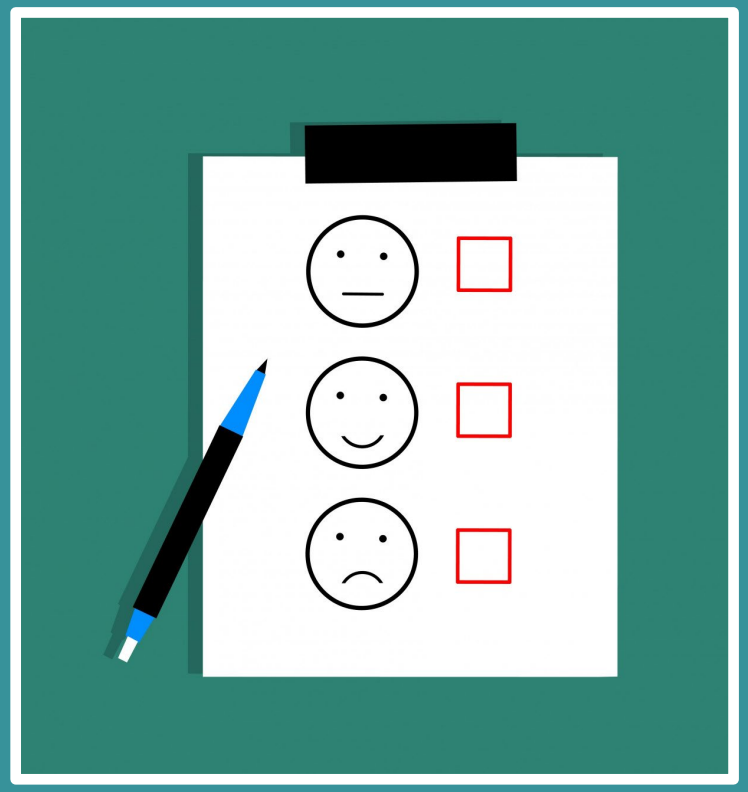
Training Evaluation



Go to this website to provide your feedback on today's training:
LINK:
https://www.surveymonkey.com/r/72D2BB3

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Resources

Documentation Resources

- QM Website
- BHRS Documentation Manual for MH
- Progress Note PDF Version

Coding Resources

- BHRS Service Codes Cheat Sheet for MH
- Location Codes Index for MH
- Scope of Practice Matrix (SUD and MH)

Additional Resources

- Avatar NX Updates and Tips
- BHRS CalAIM Hub

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Questions?