SUD Treatment Progress Note Instructions

REQUIRED FORM:

This form is a required document in the client file to document SUD services provided and includes progress toward achieving the client's recovery or items identified on the client's problem list.

WHY:

Progress notes are a basis for planning care and treatment across providers and programs, a legal record describing treatment provided for reimbursement purposes, and an effective communication tool. Remember that clients have a legal privilege to view their medical record, so it is recommended to minimize clinical or programmatic jargon.

WHEN:

This form is to be completed to document all services provided to a client.

This form must be completed within 3 business days of providing a service, or 1 calendar day for crisis services. Per BHIN 23-068, the day of service shall be considered day zero (0).

COMPLETED BY:

Each progress note is written by the SUD counselor, LPHA, or Peer Support Specialist who provided the service.

RESIDENTIAL PROGRAMS AND OTHER BUNDLED SERVICES:

Providers shall complete at minimum a daily progress note for services that are billed on a daily basis (i.e. bundled services such as DMC-ODS Residential Bed Days.) If a second, unbundled service is delivered on the same day, there must be a separate note to support the unbundled service(s) (i.e. Peer Support Specialist Services, Case Management or Clinical Consultation). All notes should still contain all the elements below.

ELEMENTS:
(Note: Underlined sections below are REQUIRED and the rest are optional):
Progress notes shall be typed or legible if handwritten

- **Client Name:** Complete client's full name.
- **Client ID:** Complete the client ID number as determined by agency guidelines.
- **Service Date:** Complete date of the service.
- **Duration of Direct Client Care for the Service**
    - Note: If billing a 24-hour bundled service (i.e. bed day), enter "bed day" in this field
- **Total Documentation Time in minutes (optional)**
- **Total Travel Time in minutes (optional)**
- **Total Time (including: service, documentation, travel) in minutes**
    - Note: If billing a 24-hour bundled service (i.e. bed day), enter "bed day" in this field
- **Language of Service (if other than English)**
- **Translator Utilized (if applicable)**
- **Location of Beneficiary at the Time of Service**: Refer to reference page for codes and location

descriptions and select appropriate code from drop-down list.

- **Contact Type** (F-F = face to face, TEL = Telephone, TH = Telehealth, COM = In Community, NC = No Contact)
- **Service Type** (IND = Ind. Counseling, GR = Group Counseling, CC = Care Coordination, MAT = Medication Assisted Treatment, CLC = Clinician Consultation, BED = Bed Day)
- **EBP Utilized** (progress note must document specifics of how EBP was utilized the narrative)

Progress Note Narrative Section: A complete progress note addresses:

1. A brief description of how the service addressed the beneficiary's behavioral health needs (e.g. symptom, condition, diagnosis, and/or risk factors).
2. A brief summary of next steps. For example: collaboration with other providers, goals and actions to address health/social/educational/other services needed, referrals, discharge and continuing care planning
3. Best practice is to include clear documentation of how evidence-based practices were used in the service provided.
4. **Group Services only:** Shall also include a brief description of the beneficiary's response to the service.
5. The content of the progress note shall support the service selected. Some notes may contain less descriptive detail than others (i.e. a participant that chose not to spoke in a group compared to one who was more actively engaged).
6. A separate care plan is no longer required (i.e. Peer Support Specialist Service, Perinatal Plan of Care, documentation of a client's need for a physical exam, etc.) Required care plan elements can be notated within the assessment record, problem list, progress notes, or by using a dedicated care plan template.

Telehealth Consent: Documentation of client consent to receive services via telehealth or telephone must be documented, and may include documentation of verbal consent. A one-time consent in the client file is considered sufficient. Providers can refer to the DHCS Telehealth model consent language page for an example.

Providers can refer to the CalMHSA documentation guides for examples of effective documentation.

Provider Signature: All entries must include the printed name with title/credentials, signature with title/credentials and date of the staff completing the progress note. **Note:** the signature must either be a wet signature or a digital signature. A typed name in the signature line is not considered a signature and may be out of compliance.