MISSION

To partner with individuals, families and the community for recovery from serious mental health and substance abuse issues and to promote wellness, resiliency and hope.

CORE VALUES

The following core values are fundamental to our actions and reflect how we choose to conduct ourselves. Although our external environment may vary greatly, these values remain constant. Our commitment to these values will guide our actions and be consistently reflected in our relationships with one another, our clients, our community partners and providers.

RESPECT: We will honor the value of all individuals and their experiences.

GRACE: We hold the trust of others through kindness and respect.

DIGNITY: We believe in an individualized approach to care that honors the person.

HOPE: Is a life-affirming component to self-determination, recovery and resiliency.

SELF-DETERMINATION AND GROWTH: As individuals, we have the right to determine how we live. Change is always possible.

DIVERSITY: Embracing and respecting diversity is vital to an individual’s and community’s success.

COLLABORATION: Working together through integrity and the collective wisdom of our partners, we become stronger.

EFFICIENCY AND ACCOUNTABILITY: We are stewards of the public trust.

EXCELLENCE IN PREVENTION, TREATMENT AND CARE: We will provide continuity in prevention, treatment and care with a minimum of delay and the best possible outcomes for the individuals and families we serve.
For the Department’s vision, we sought to develop a statement that appealed to our core values, yet was simple in serving as a guide and providing focus. Our vision is:

“A continuum of care that promotes the behavioral health of the entire community.”

Butte County Department of Behavioral Health (BCDBH) values our clients and encourages each client to participate in his/her care. With this in mind, we encourage our staff to involve clients in his/her documentation when appropriate to include using client(s) own words when applicable. Our desire is to partner with our clients in care to promote wellness and recovery at every step of care.

Butte County Department of Behavioral Health Department has produced the Clinical Documentation Manual to serve as a guide for all clinical chart records, but does not take the place of clinical supervision. This manual serves as a guidance document to promote excellent, accurate and timely documentation of the services we provide to our community. We strive to provide excellent care to our clients, and accurate documentation is a crucial step in the process of delivering excellent care. A client’s chart should depict a comprehensive record of treatment and have a “flow” often referred to as "The Golden Thread".

APPLICATION
Managers and supervisors are encouraged to use the documentation manual as a reference and resource to train staff. The documentation manual defines key concepts, explains documentation requirements, and provides examples of how to document various types of mental health services. All staff providing clinical services should refer to the manual whenever they need an answer to a documentation question.

Inevitably, situations arise when staff will need clarification or further direction. In such cases, the program manager or supervisor should be consulted. Quality Management staff will be available to address any further questions concerning documentation.
The manual will be used for all client records regardless of payer source. Specialty programs within the department may have unique documentation requirements (i.e. a grant funded program may have specified additional items to include in the chart). Samples and examples are meant to illustrate the topic and are not meant to replace clinical supervision or sound clinical judgment.

*Note: A client is a person who accesses and receives outpatient mental health services; a client is also known as individual, patient, consumer, beneficiary, etc.

**SOURCES OF INFORMATION**

This Clinical Documentation Manual is to be used as a reference guide and is not a definitive single source of information regarding chart documentation requirements. This manual includes information based on the following sources: the California Code of Regulations (Title 9), the California Department of Health Care Service’s (DHCS) letters/notices, the Butte County Department of Behavioral Health’s (BCDBH) policies & procedures, directives, and memos; and Quality Management’s interpretation and determination of documentation standards.

**ORGANIZATION & SYMBOLS**

This manual is organized into color-coded sections and clickable links to help you navigate it with as much ease as possible. This manual contains many links connecting you to either online resources or to other parts of the document. If ANY word or phrase is underlined, this means that it can be clicked on for instant access to another part of the manual; these are called “Section Shortcuts.” The following symbols and graphics are used to help bring clarity and simplicity to the manual as a whole:

**DOCUMENTATION TIP**

*These can be found throughout this document and provide answers to some frequently asked questions. All 'Documentation Tips' will be denoted with the above graphic with italicized and turquoise-blue colored text below the graphic.*

This symbol indicates that you should pay careful attention to the following information. The information will be clearly labeled with "CAUTION".
Each section will be denoted with a special symbol relating to the subject of the section (the example to the left is for the “Scope of Practice” section). The entire section will utilize the symbol and the colors of the symbol.

This mouse and link symbol indicates an internet link. These links will be clickable in the PDF format.

This indicates a clickable “section shortcut” to the Table of Contents or head of the section. It appears below every page number within this manual. The intention is that if you click on a “section shortcut” within the Table of Contents and are taken to the desired section, you have a shortcut that can take you back to the Table of Contents in case you wish to jump to another part of the manual. **Click on the hexagon for a demonstration.**

**TECHNICAL ASSISTANCE**
The Quality Management staff is available to answer questions about this documentation manual or documentation issues in general. You can reach us at 530.879.2456
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Our guide on the scope of practice and answers the basic question: “Who can provide each service?”

Provides information regarding informed consent

Covers medical necessity and how to establish this for each client prior to delivering any service and throughout client care.

Provides detail on how to complete a clinical assessment and a clinical treatment plan. Gives detailed information on what is expected to be included in each of these forms/options.

Addresses all of the service activities that are reimbursable. We’ve provided definitions, descriptions of the activities, and other useful information.

Introduces dual diagnosis and how to properly identify and write a dual diagnosis.

Presents some general guidelines for the discharge process.

Presents some general guidelines for writing progress notes.

Addresses activities that are not reimbursable. Take note that this list has been expanding over the years.

Simplifies the lockout rules.

Shows examples of chart documentation (fictitious clients); Section for demonstration purposes only. Please follow the manual instructions on dates and timelines.
It is expected that staff will provide services allowed in their job classification and by credentials (i.e. licensure, Board registration, education, training, and experience). Further limitations may be due to level of experience in a specific service category or by department restrictions.

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<th>STAFF ELIGIBLE TO PROVIDE SERVICE</th>
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| Physicians, Nurse Practitioners   | • Assessment  
• Plan Development  
• Crisis Intervention  
• Collateral  
• Individual Therapy  
• Family Therapy  
• Group Therapy  
• Rehabilitation (individual, group)/Intensive Home Based Services  
• Brokerage / Targeted Case Management/Intensive Care Coordination  
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• Collateral  
• Rehabilitation (individual, group)/Intensive Home Based Services  
• Brokerage / Targeted Case Management/Intensive Care Coordination  
• Therapeutic Behavioral Services  
• Medication Support (education, monitoring)  
• Medication Administration |
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<td>Behavioral Health Workers</td>
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<td><strong>1st Year Graduate Student Intern</strong></td>
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<td><strong>Undergraduate Student Interns</strong></td>
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Informed Consent for Treatment must be obtained prior to providing services (first face-to-face contact) to a client and is the first step to be completed between the clinician* and the client or the client’s parent/guardian. Per Title 22, section 101, “informed consent means that a [client] grants, refuses or withdraws consent to treatment after the MH provider presents the [client] with information about the proposed mental health services, mental health supports, or treatment, in language and manner that the [client] can understand”. At BCDBH, we obtain written informed consent at the initial admission (first face-to-face contact) to services and annually thereafter. This consent covers both outpatient and inpatient services and is valid unless the client withdraws the consent. Discussion about informed consent must be documented in the client’s clinical record. If a client is unwilling or unable to provide informed consent the reason, as well as attempts to obtain informed consent must be documented in the client’s clinical record.

For treatment with psychotropic medications there are additional documentation requirements for informed consent. Consent for Psychotropic Medication Therapy must be completed by the medical staff prescriber and the client or the client’s parent/guardian. This documentation shall include, but not be limited to, the reasons for taking such medications; reasonable alternative treatments available, if any; the type, range of frequency and amount, method (oral or injection), and duration of taking the medication; probable side effects; possible additional side effects which may occur to clients taking such medication beyond three (3) months; and that the consent, once given, may be withdrawn at any time by the client. Medication consent must be obtained prior to prescribing medication and whenever a new medication is prescribed.

*During a crisis on an unopened client, it is permissible for a behavioral health counselor to obtain informed consent during the face-to-face contact.
Butte County Department of Behavioral Health conducts a brief screening assessment with clients to establish medical necessity.

The screening includes completion of the following options in the Electronic Health Record (EHR):

- Informed Consent
- BCBDH Acknowledgement of Receipt of Notice of Privacy Practices
- Acknowledgement of Receipt of Guide to Medi-Cal Mental Health Services
- Acknowledgement of Receipt of Provider List
- BCDBH Medical Necessity Determination
- BH Mental Status Exam
- BCDBH Diagnosis.

If a client meets medical necessity, an initial assessment and a treatment plan will also be completed. The initial assessment must include all diagnostic criteria required in the DSM to support the primary diagnosis and describe the functional impairments that significantly impact the client’s day-to-day life. All long term clients are required to have an initial assessment and treatment plan on record.

Note: Any client open for 60 days or greater is considered a long term client.

**MEDICAL NECESSITY CRITERIA**

Clients must meet the following medical necessity criteria as described in Title 9 (§1830.205, 1830.210) in order to be eligible for outpatient specialty mental health services:

- The client must have an included qualifying current Diagnostic and Statistical Manual (DSM) mental health diagnosis that is the focus of treatment. See [APPENDIX A](#) for a list of included and excluded diagnoses
- **As a result of the mental health diagnosis, there must be one of the following criteria:**
  - A significant impairment in an important area of life functioning (e.g., Living Arrangement/Housing, Activities of Daily Living, Primary Support Group, Education, Financial Economic Issues, Access to Health Care Services, Social Relationship/Environment/community, or School Situation)
b. A reasonable probability of significant deterioration in an important area of life functioning

c. For a child (a person under the age of 21 years), a reasonable probability that the child will not progress developmentally as individually appropriate

Must meet each of the interventions criteria listed below:

a. Focus of the proposed intervention must address the condition identified

b. The proposed intervention will do, at least, one of the following:
   
   i. Significantly diminish the impairment
   
   ii. Prevent significant deterioration in an important area of life functioning
   
   iii. Allow the child to progress developmentally as individually appropriate

c. The conditions would not be responsive to physical health care based treatment (Primary Care Physician)

Medical Necessity is gathered on the Medical Necessity Option in MyAvatar (See SECTION XI for a sample of a completed Medical Necessity Determination form).

- The Medical Necessity Determination Form is also used as the annual assessment by right clicking in the presenting problems box >selecting System Templates >Annual Assessment. This will incorporate additional questions that need to be answered annually.

In order to meet Medical Necessity Regulation, every note and every document (treatment plan, assessment, medical necessity determination, etc.) must be unique and an accurate description of the client’s current state at the time that documentation is written.

Each document must be able to “stand alone” and therefore meet medical necessity criteria without referring to another document. This includes every document in the chart we use to ensure we meet Medi-cal billing requirements.
Examples:

1) Treatment plans: should be unique and are meant to be updated annually or more frequently as the client either makes progress, or his/her needs or goals change. Treatment plans remaining the same each year can potentially be viewed as if our services are not helping or that we really are not in tune with our client's goals.

2) Assessments/Medical Necessity Determination/Mental Status Exams: client’s not only age each year, but will have likely made some life changes, have at least some symptom differences, and have a response to our treatment that can be accurately captured in an annual assessment. It should be an update and include a summary of the client’s care and services over the past year. Documents that are capturing the client’s current functioning such as a Mental Status Exam, should not be exactly as the year prior as well. It would be expected that at least some changes are present due to treatment.

3) Progress notes: each time a client comes in for a service, each progress note should “stand alone” and include the client’s unique presentation and response to our intervention in each session. Notes that are exactly the same each week, or have very little variance are not only subject to disallowance, but can indicate a quality of care concern, or be viewed as fraud or abuse.

CAUTION: BCDBH does not allow for Cut and Paste templates or cloning of any kind to be used in our medical records.
The mental health assessment serves as the foundation for the client’s plan of care. The assessment reinforces eligibility to receive outpatient specialty mental health services, drives the treatment planning process, and provides the basis for ongoing changes in treatment delivery and discharge planning.

**AN EXCELLENT INITIAL OR UPDATED ASSESSMENT MUST INCLUDE:**

1. A description of the client’s current symptoms and behaviors that supports the required DSM criteria for each diagnosis (including severity, frequency, duration, etc.)
2. All sections must be completed (use N/A if not applicable). It is not acceptable to leave questions or sections blank
3. A detailed description of the client’s functional impairment(s)
4. A list of the client’s strengths, in achieving client plan goals:
   a. Abilities and accomplishments
   b. Interests and aspirations
   c. Recovery resources and assets
   d. Unique individual attributes
5. A description of the client’s cultural/spiritual/linguistic factors which may include: ethnicity, gender, spiritual beliefs, beliefs around birth/death, family traditions, healing rituals, view of authority figures, family structure/dynamics, roles, how conflict is handled, military service.
6. Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, complementary and alternative medications (CAM), over-the-counter (OTC), and illicit drugs. These questions are embedded in the Medical Necessity Determination Form.
   a. If a substance-related diagnosis is indicated, it **must** be included on Axis I.
7. Both the numerical code and full clinical name of the diagnosis should be listed, based on the department recognized DSM. For example, “Axis I: 313.81, Oppositional Defiant Disorder.”
8. A full Five Axial Diagnosis must be completed.
   a. Please note Alcohol and Drug Diagnosis shall be listed as a Secondary Diagnosis on Axis I; if the Alcohol and Drug Diagnosis is the client’s primary diagnosis the
client does not qualify for specialty mental health services and the client should be provided a referral to Alcohol and Drug Services.

9. Any updated diagnosis must be accompanied by a progress note in order to document the change, and the BCDBH diagnosis option in MyAvatar must be completed with the updated information. In the event of a new or updated diagnosis, the treatment plan will be reviewed and updated as necessary.

The assessment bundle in MyAvatar must be completed for all long term clients and includes the following Documents:

- Informed Consent
- BCDBH Acknowledgement of Receipt of Notice of Privacy Practices
- Acknowledgement of Guide to Medi-Cal and Mental Health Services
- BCDBH Medical Necessity Determination
- BCDBH Diagnosis
- BCBDH Initial Assessment
- BH Mental Status Exam

Additional documents required include:

- Release of Information (as appropriate)
- Treatment Plan
- CANS (for Children)
- MORS (for Adults)

1. INITIAL ASSESSMENT

The initial mental health assessment is required for all clients meeting medical necessity who are not currently opened or are new to the outpatient mental health system (or are returning for services after being discharged from all outpatient services for more than 30 days). This assessment shall be completed within 60 calendar days of the client’s signature on the consent to treatment form or that of the legal guardian or adult. Assessments are considered valid* only when signed by a LPHA* and finalized in the EHR (the date of validation appears by the LPHA staff
signature). Please refer to the BCDBH Chart Paperwork Timelines in APPENDIX B for timelines and due dates for each item required in the clinical chart.

2. UPDATED/ANNUAL ASSESSMENT

- An updated assessment must be completed annually on or before the informed consent date.
  - This can be done using the Medical Necessity Determination Form by right clicking in the presenting problems box >selecting System Templates >Annual Assessment. This will populate additional questions needed to make the Medical Necessity Determination Form act as the updated assessment.

- Updated assessments are required to be comprehensive and complete. In other words, the updated assessment must stand alone and not simply be the same as the initial assessment or initial medical necessity determination form. When completing an updated or annual assessment the clinician must complete a new form.

- Updated assessments must clearly state why the client continues to require services in the presenting problem section of the assessment and in the medical necessity determination form (i.e. this is what establishes continued medical necessity).

- Updated assessments must contain a summary of the treatment provided in the past year and the response to that treatment.

**DOCUMENTATION TIP**

Clients who are discharged from all open programs and return for services within 30 days or less can be re-opened without having to re-do all opening paperwork. Consents, assessments, treatment plans, etc. can be defaulted from a previous program as long as the information is current and was previously completed less than one year ago.

You must be able to justify why treatment shall continue, for example: “If a client has received individual therapy each week for a year and has not made significant progress why would we continue this same frequency, duration, and type of treatment?”
3. ASSESSMENTS WHEN CLIENT TRANSFERS TO OR ARE OPENED TO A NEW PROGRAM

If an open client transfers to a new program or is added to a new program, the clinician may use one of the following three options:

1. Complete a new assessment within 30 calendar days of opening in the new program, if indicated.

2. Accept the prior assessment, if satisfactory, as long as it was completed within the past year and attest that they have pulled the document forward and not made any changes. This assessment must be updated within a year of the existing annual informed consent signature date.

3. If there have been changes or the prior assessment is incomplete the clinician must complete a new initial assessment within 30 calendar days in the assessment (refer to SECTION XI) for examples.
V. TREATMENT PLAN

OVERVIEW

Whereas the assessment documents the current mental health condition and functional impairments of the client, the Treatment Plan is the guiding force behind the delivery of care. The plan helps the client and the clinical staff to collaborate on the client’s recovery goals. Ultimately, treatment should result in services provided at the lowest level of care needed or discharge to the community. For an example of a treatment plan see SECTION XI.

TREATMENT PLAN BASICS

- The Treatment Plan is an agreement between the client and the clinician that states which mental health problem(s) will be the focus of treatment. The Treatment Plan consists of specific goals, objectives, and the treatment interventions that will be provided (See “Signatures” at the end of this section).

- There needs to be a clear connection and flow from the DSM diagnosis and functional impairments in the assessment to the problem, goal, objectives, and interventions in the treatment plan.

- A Treatment Plan is required to be completed with all required signatures in each outpatient mental health episode. There are no exceptions! The Treatment Plan shall be used for all service activities.

- A client receiving both general mental health and medication support services will have an “integrated treatment plan.” Integrated plans include both general mental health interventions and medication interventions. If the client is receiving integrated treatment the LPHA is encouraged to coordinate care with the psychiatrist or prescriber as needed to provide continuity of care and inform the treatment planning process.

- The Treatment Plan is only valid from the date in which both the LPHA and the client have signed the plan. In the event of a new diagnosis, a new Treatment Plan may be needed if clinically appropriate. Please consult with your clinical supervisor if needed.

- BCDBH requires a minimum of two objectives with two interventions per objective on each treatment plan.
Please note the only services that can be provided prior to the completion of a treatment plan (must be within 60 days) are assessment (3310), plan development (3910), and crisis intervention (3710/3715).

**Treatment Plan Timeline**

The completion of the Treatment Plan is subject to specific deadlines and signature requirements, as described below:

1. INITIAL

An initial plan can occur in two primary instances: new to services or transferring to a new program.

1. New to Services: The initial Treatment Plan shall be completed within 60 days of the client’s entry to a program RU. This deadline applies to clients who are new to BCDBH or are re-entering services after previously being discharged.

2. Transfer: For existing clients who enter a new program or if the client transfers to a different program, the plan if still appropriate can be pulled forward* and utilized in the new program. When pulling a document forward, the person pulling it forward will attest that they have pulled it forward and not made any changes. In order to bill for services in a new program, each client must have a valid treatment plan within that treatment episode.

**DOCUMENTATION TIP**

Check the content and the dates of the plan to be sure the services you will deliver are covered in the plan. If you do not agree with the current plan, update it with the client!

2. RENEWAL

Each Treatment Plan can be authorized for up to one year, however many clients achieve goals prior to a year, and plans shall be updated prior to a year based on goal achievement. A plan should not be the same year after year. If our current plan did not help the client achieve his or her goals, the plan must change. If the current plan did work, update to reflect the changes.
An annual treatment plan must be completed on or before the expiration of the informed consent date.

- For example, the initial informed consent is signed on 5/2/13, the initial treatment plan is completed on 6/30/13; the annual treatment plan will be due on or before 5/1/14.
- Subsequent treatment plans will be due prior to the expiration of the most recent informed consent date.

For a complete list of all documentation timelines please see the Chart Documentation Timelines in APPENDIX B.

3. LATE RENEWAL

If the renewal period passes and the next Treatment Plan is completed late, there will be unauthorized days that should not be claimed (i.e. the renewal date is July 1st but the Plan is completed on July 7th, then July 1st through 6th would be unauthorized for all services, except crisis intervention, during that time period).

TREATMENT PLAN COMPONENTS

The treatment plan contains the following components to identify the needs and services of the client: Problems, Goals, Strengths, Barriers to Treatment, Objectives, Interventions, and Signatures.

PROBLEMS

The problem is the focus of treatment based on the mental health diagnosis, which includes symptoms, behaviors, and life functioning.

- **Example**: A client diagnosed with Schizophrenia – may have symptoms such as auditory hallucinations, delusions, disorganized thinking, poor hygiene, social withdrawal, or other issue that may interfere with securing stable housing and/or maintaining positive family relations or otherwise impact his/her life functioning.
- **Example**: A client diagnosed with Oppositional Defiant Disorder – may have symptoms such as arguing with adults, yelling and screaming, temper tantrums, blaming others, or not taking responsibility which impacts his/her life functioning at school.
In some cases, there may be two diagnoses that are the focus of treatment (e.g. Bipolar Disorder & PTSD), so there could be two problems identified.

PERFECTING THE "PROBLEM" STATEMENT

An excellent problem section will include the client’s impairment in life functioning that is related to the diagnosis, i.e. maintaining housing.

- **Good Example:** Client has depressive symptoms of insomnia, isolation, social withdrawal, decreased appetite, suicidal ideation, and poor concentration, which interferes with client’s ability to achieve daily activities such as work or school.
- **Another Good Example:** Client’s psychiatric symptoms of schizophrenia are evidenced by disorganized thoughts, irritability, paranoid ideations, auditory and visual hallucinations which lead to difficulties maintaining housing.
- **Example of a Poorly Written Problem:** Client has symptoms of major depressive disorder (specific symptoms/functional impairments are missing).

**GOALS**

The goal is the client’s desired outcome associated with their problem. This is where we help the client articulate what life could be like without the problem, or with better coping with the problem.

The goals should be stated in the client’s words whenever possible.

- **Example:** Billy would like to have more friends. Or “I would like more friends.”
- **Example:** Diane desires to live independently. Or “I would like to live in my own apartment.”

**STRENGTHS**

Environmental factors that will increase the likelihood of success such as:

- Community supports, family/relationships, support/involvement, work, etc. may be unique to racial, ethnic, linguistic and cultural (including lesbian, gay, bisexual and transgender) communities
- Identifying the person’s best qualities/motivation
- Strategies already utilized to help (what worked in the past)
- Competencies/accomplishments interests and activities, i.e. sports, art identified by the consumer and/or the provider
- Motivated to change
- Has a support system – friends, family
- Employed/does volunteer work
- Has skills/competencies: vocational, relational, transportation savvy, activities of daily living
- Intelligent, artistic, musical, good at sports
- Has knowledge of his/her disease
- Values medication as a recovery tool
- Has a spiritual program/connected to a church
- Good physical health
- Adaptive coping skills/ help seeking behaviors
- Capable of independent living

Use the information on strengths (including cultural strengths) to identify the individual/family attributes and skills. Identify resources that will be particularly significant to supporting the client in achieving their goals

When considering strengths, it is beneficial to explore other areas not traditionally considered “strengths,” Such examples include: an individual’s most significant or most valued accomplishment, what motivates them, educational achievements, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, personal heroes, most meaningful compliment ever received, etc.

**OBJECTIVES**

An objective is a description of what the client will do to show progress toward a goal.

An objective will:

1. Address a problem (functional impairment)
2. Be observable and/or measurable
3. Have baseline and target levels

Objectives should not be absolutes, that is, we should not expect a person exhibiting a behavior 8 times per day at baseline to go to 0 times per day to achieve the objective. With the exception of physical assault or sexual perpetration on others, this should always have a goal of 0 times per day. Smaller and more reasonable steps can assist in successes in the client’s life and motivate towards goal achievement.
• Remember, you can always update the plan when a goal is achieved, so a movement from 8 times per day to 5 times per day, for example, can be updated once achieved to assist that movement from 5 times per day to be 2 times per day etc. Success breeds success.

It is important to track client progress on objectives closely. Update the treatment plan as needed or begin transitioning the client to a lower level of treatment or discharge when objectives have been met or functioning has been restored.

**DOCUMENTATION TIP**

The ‘Objective Template’ below can assist in writing a simple but excellent objective.

**OBJECTIVE TEMPLATE:**

CLIENT NAME will **INCREASE/DECREASE** FUNCTIONAL IMPAIRMENT from BASELINE to TARGET

**EXAMPLES OF A GOOD OBJECTIVE:**

• **Tom** will **decrease** contacts with law enforcement for disturbing the peace from 5 times a week to 2 times a week or less.

• **Sally** will **increase** attendance at school from 0 days to 3 days per week.

**EXAMPLE OF A POOR OBJECTIVE:**

• “**Decrease psychiatric symptoms**.” - (The objective lacks specificity, frequency, and duration related to specific symptoms and is too vague to measure).

**Do NOT use percentages (%). They are difficult to track and measure.**

**INTERVENTION**

Interventions are the therapeutic activities provided by staff to assist the client in attaining the objective in each goal. In other words, how can staff provide a clinical service to assist the client to meet his/her goals? There must be at least two interventions per goal provided by staff members.
Interventions may also include what the client or client’s support person is going to do to work towards the goal (i.e. therapeutic homework, attending a social skills group, wellness group, etc.).

Interventions must address the objectives and **must include duration and frequency**. All services must be included in this section.

- One way to capture the required elements of an intervention is to utilize the following intervention template:

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>FREQUENCY &amp; DURATION</th>
<th>ACTION WORD</th>
<th>FUNCTIONAL IMPAIRMENT</th>
</tr>
</thead>
</table>
  | EHR Documentation examples ([Section XI](#)) included later in this manual show an alternative way to capture the required elements for an intervention. These examples show interventions using the mandatory duration and frequency fields in the MyAvatar client Treatment Plan.

- **EXAMPLES OF A GOOD INTERVENTION USING TEMPLATE:**
  - Clinician will provide **individual therapy** and will use cognitive behavioral techniques to assist client in **reducing** symptoms of **self-deprecating** and **suicidal ideation**. (weekly for one year)
  - Client will attend **social skills group** to **improve** **social skills** by interacting with same aged peers. (weekly for one year)
  - Staff will provide **rehab services** to **model and encourage** client to practice **social skills**. (2 times/week for 6 months)
  - Clinician will use **structured play therapy** (stop, think, and listen game) to **increase impulse control skills**. (weekly for 3 months)
  - Medical staff will provide **medication education** (side effects, medication efficacy) to **support adherence to medications** and reduce symptoms. (1 time every 3 months for one year)

- **EXAMPLES OF A SUPPORT PERSON INTERVENTION:**
  - Mom will play with Johnny for at least 20 minutes a day for the next six months to **increase** his abilities to gain positive attention and encourage bonding
Brian's daughter will drive him to bingo 1x/week for the next 6 months to assist him to increase socialization and decrease isolation.

Documentation Tip

Interventions not included in the treatment plan are subject to disallowance; i.e., group therapy being provided without listing it as an intervention. Also interventions that are addressed in the treatment plan and then never utilized may also be reviewed and should be addressed in a progress note as to why the intervention is not being provided, if this continues it may indicate needing to update the treatment plan.

SIGNATURES

- The “Signatures” section indicates the client’s participation and agreement with the Treatment Plan (CCR Title 9 Division 1, §1810.440).
- Treatment planning sessions shall always be documented in a progress note (as plan development). An excellent progress note contains information about the client and the client’s significant support person’s participation in the treatment planning process and/or signing the plan.
- The client must be offered a copy of the Treatment Plan and acknowledge our offer of the copy by signing the plan as the signature states: “Client helped develop, understands, agrees with the goals, and has been offered a copy of this client plan.”
- Signatures are required by the client and/or legal guardian and the LPHA.
- The client or his/her legal guardian’s signature is required in the Treatment Plan:
  - If the client does not or cannot sign the plan, then a progress note shall document the reason for the missing signature.
  - Ongoing efforts to obtain client’s missing signature must be made and documented.
  - Exception: If the client refuses to sign, then as best as possible, ascertain the reason. Renegotiate the goal, if that is the reason. If the client agrees with the goal and the treatment proposed but still refuses to sign the Treatment Plan then document that fact in the progress note.
A treatment plan without required signatures or date is subject to disallowance. Don’t be late!

THERAPEUTIC BEHAVIORAL SERVICES (TBS) IN THE TREATMENT PLAN:
For the Therapeutic Behavioral Services (TBS) treatment plan, the organizational provider shall create the TBS treatment plan. Please refer to the TBS SECTION of this manual for further detail.
VI. DUAL DIAGNOSIS

Dual-diagnosis services may be provided for clients with both mental health diagnosis and substance-related diagnosis, when the primary focus of treatment is on the mental health diagnosis. Primary focus means more than 50% of services provided address the mental health diagnosis. The goal to address the use of substances (to cope, or reduce mental health symptoms) must be the secondary goal on the treatment plan. The primary goal on the treatment plan must address the mental health condition. While dual diagnosis can be treated a majority (50% or more) of the services provided to the client must be focused on the mental health condition, rather than on the substance use condition.

FOCUS OF SERVICE

Dual-diagnosis services provided by the mental health clinics of the Department of Behavioral Health must focus on the mental/behavioral health needs of the client. Dealing with mental/behavioral health concepts and needs is acceptable including how the client:

- Recognizes and attempts to meet needs
- Deals with emotions
- Makes plans
- Carries out responsibilities, etc.

Documentation Tip

Remember if services provided primarily focus on sobriety or dealing with aspects of the client’s substance use or dependence (whether to use, how much to use, how to quit, etc.), the services will be subject to audit disallowance.

OBJECTIVES

An objective will address a problem (functional impairment), be observable and/or measurable, and have a baseline and target. NOTE: the ‘Objective’ in MyAvatar is equivalent to previous treatment plan “Goal” used in standard treatment plans of the past.
An intervention is the therapeutic activity to be taken by staff to assist the client to attain the goal.

### DUAL DIAGNOSIS SAMPLE GOAL (OPIOIDS):

- **PROBLEM:** James uses prescription opioids to numb feelings of pain (emotional and physical)
- **GOAL:** “I need to stop using (prescription opioids) because it’s causing problems at home and I have been missing work.
- **OBJECTIVE:** James will decrease opioid use from 3 times per day to one time per day.
- **INTERVENTIONS:**
  1. Individual Therapy weekly to assist James in identifying early warning signs, or triggers, that increase the desire to use opioids over the next 12 months.
  2. Rehabilitation services or individual therapy weekly to teach relaxation skills and coping skills to James to use when relapse triggers occur or when intense emotions arise (anxiety, anger, fear) to decrease desire to use opioids over the next 12 months.
  3. Rehabilitation services or individual therapy monthly to assist James in identifying the benefits/positive outcomes that result from not using (in marriage, job, with children) to decrease his use of opioids for the next 12 months.
  4. Individual Therapy monthly to teach James to keep a diary of relapse triggers and how he managed them to reinforce his efforts to stop using opioids for the next 12 months.

### DUAL DIAGNOSIS SAMPLE GOAL (CANNABIS):

- **PROBLEM:** Client uses cannabis when he feels anxious.
- **GOAL:** “I want to feel better.”
- **OBJECTIVE:** Client will reduce cannabis use from daily to 3 times a week or less within 12 months.
INTERVENTIONS:

1. Rehabilitation services and individual therapy weekly for 12 months to assist Client in identifying ways he has successfully managed anxiety in the past.

2. Individual therapy weekly for 12 months to assist client in recognizing triggers to anxiety.

3. Rehabilitation or group rehabilitation weekly for 12 months to educate client about the side effects of cannabis and increased anxiety

4. Rehabilitation or group rehabilitation weekly for 12 months to teach, model, and encourage the use of healthy coping techniques

5. Individual therapy weekly for 12 months to explore both the positive and negative consequences of client’s substance use as it relates to anxiety

6. Brokerage services to refer client to dual diagnosis group if available or other needed community resources (12 months).
1. When a client has either met their goals and can transition to a lower level of care or out of services a discharge bundle must be completed.

2. The discharge bundle includes a discharge summary as well as a diagnosis option to record the client’s discharge diagnosis. This bundle can also be utilized when a client discontinues services without notifying staff and fails to respond to phone calls or letters offering additional services.

3. Review next section “Documenting by Service Type – Progress Notes” for further information on Discharge.
This next section provides guidance on how to document for each service type into a progress note. Each section is organized with an overview of the function of the service type then shows the billable activities associated with that service type. Examples are included along with tips for writing a progress note to capture each service type.

Progress notes are a summary description of what was accomplished or attempted at the time the service activity was delivered that assisted the client to make progress towards goals. The key word is “progress.” In general, progress means “to advance or make steady increases towards a goal.”

Progress notes should be written objectively. Refrain from using negative language about clients. Remember that a client can request his/her chart at any time, or a court may subpoena a chart.

Every service activity must have a separate, corresponding note (i.e. if you provided two different services to the same client in the same day, each service requires a separate note).

All progress notes need to include the following items:

- Date of each service
- Duration of service in exact minutes
  - Documentation/Travel time
- The Treatment Plan objective being charted to
- The clinical intervention(s)
- Client’s clinical response to the intervention
- Plan for continued treatment
  - Record any therapeutic assignments (homework) for the time between sessions
g. Must be legible

h. Notes entered by DragonSpeak/transcription program must be proofread prior to final submission into EHR

i. Service provider’s handwritten or approved electronic signature
   
   i. Signatures must include: staff’s professional degree, license or job title
   
   ii. Signatures must be legible or accompanied by a printed name

3. Every service is expected to be documented in a timely manner. All staff are encouraged to use concurrent documentation (write your note with the client present) to write notes in real time, eliminate post service documentation time, and increase the client’s involvement in his or her clinical record.

4. When more than one staff member participates in a service for the same client, each staff must write a note for the time they were present and billed for the service. For example: if two staff participate in a plan development meeting with a client, each staff member writes his/her own note to represent their contribution to the meeting.

   **CAUTION:** We cannot write notes that simply state “See other staff member’s progress note” and must write a note for each service delivered. The only EXCEPTION to this is group notes which allow co-practitioner time to be entered. (Group notes operate differently than other progress notes).

5. BCDBH requires the use of the D.I.R.T. format for the following service types:

   - Assessment, Rehabilitation, Therapy, Collateral, Crisis Intervention, Intensive Care Coordination, Intensive Home Based Services and Therapeutic Behavioral Services.

      **D (DESCRIBE)** the presenting problem, how the client presents him/herself, or the reason for the service activity.

      **I (INTERVENTION)** What treatment plan service was provided by the clinician?

      **R (RESPONSE)** What was the client’s clinical response to the intervention?

      **T (TREATMENT PLAN)** What is the next step for the recovery process?
6. Refer to **SECTION XI** (Documentation Examples) for examples of notes by service type and to view notes that contain all the required elements. View **APPENDIX D** for Progress Note Formatting Guidelines.

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**Documentation Tip**

*If client has a recent history of suicidal or homicidal ideation and/or hospitalization, document potential risk in each progress note*

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**MENTAL HEALTH SERVICES – ASSESSMENT (3310)**

“Assessment” means 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 (CCR Title 9 Division 1, §1810.204) (For information on how to complete an assessment document or option, please refer to the Assessment section).

- **ACTIVITIES**
  - Assessment activities are usually face-to-face or by telephone with or without the client or significant support persons and may be provided in the office or in the community. An assessment may also include gathering information from other professionals.

  **Examples** include the following:

  - Interviewing the client and/or significant support persons to obtain information to assist in providing focused treatment.
  
  - Administering, scoring, and analyzing psychological tests and outcome measures such as FIT, CANS and the MORS.
  
  - In some instances, gathering information from other professionals (e.g., teachers, previous providers, etc.) and reviewing/analyzing clinical documents/other relevant documents may be justified as contributing toward the assessment.
  
  - Observing the client in a setting such as milieu, school, etc. may be indicated for clinical purposes.

- **PROGRESS NOTE- ASSESSMENT**

  - Each assessment activity requires a progress note. The note should contain a brief summary of what was completed during the assessment interview/session, who was
present/participated in the service delivery, and record the exact time the assessment service lasted.

- The final assessment progress note date should match the date the assessment is finalized in the EHR. An additional progress note shall be written if an assessment is appended or updated.

**CAUTION:** – A diagnosis can only be provided to a client after the clinician has met with him/her face-to-face.

**MENTAL HEALTH SERVICES – PLAN DEVELOPMENT (3910)**

“Plan Development” means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress related to the client plan. (CCR Title 9 Division 1, §1810.232) Client plans drive services and are based on the assessment.

- **ACTIVITIES**
  - Plan Development activities may be face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. Plan Development may also include contact with other professionals.
  
  Plan development activities can be conducted with or without the client, and include the five following items:
  
  - Development of the treatment plan
  - Approval of the treatment plan
  - Updating of the treatment plan
  - Monitoring the client’s progress in relation to the treatment plan
  - Discharge planning

- **PROGRESS NOTES**
  - Plan Development progress notes are expected to refer to the treatment plan (i.e. development, approval, updating, or monitoring and/or discussing updating the client’s diagnosis)
  
  - Discharge summaries document the termination and/or transition of services, and provide closure for a service episode and referrals as appropriate
Administrative tasks such as "closing out the chart," "copying," or "filing" cannot be claimed as billable services.

- **MISCELLANEOUS**
  - Plan Development may be provided during the development/approval of the initial Treatment Plan and subsequent Treatment Plans. However, Plan Development can be provided at other times, as clinically indicated. For example, the client’s status changes (i.e. significant improvement or decline) and there may be a need to update the Treatment Plan.
  
  - Plan Development may include activities without the client’s presence, such as collaborating with other professionals in the development, monitoring progress or updating of the Treatment Plan.
  
  - Multiple Plan Development service activities for one event are at risk of disallowance, if inappropriately documented. For example, if several staff members are present at a treatment team meeting in which a client’s Treatment Plan is discussed, the only staff that can bill are those who are actively involved in that client’s treatment, i.e. client’s doctor and therapist.

**Documentation Tip**

*Supervision, individual or group, is never a bill-able activity.*

**MENTAL HEALTH SERVICES – COLLATERAL (3110)**

“Collateral” means 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 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. (CCR Title 9 Division 1, 1810.206).
ACTIVITIES

Collateral activities are usually face-to-face or by telephone with the significant support person, and may be provided in the office or in the community. The client may or may not be present.

Examples include the following:
- Educating the support person about the client’s mental illness
- Training the support person to better support or work with the client

PROGRESS NOTES
- Collateral progress notes must include the staff intervention(s) identified on the client plan (e.g., educating, training, etc.) and must demonstrate how they benefit the client
- Collateral progress notes should include the role of the significant support person (e.g. parent, guardian, etc.)
- Documentation should substantiate that the support person is significant in the client’s life
- An excellent collateral progress note should document the changes that occurred as a result of educating and training the significant other, e.g., show how parents learned and demonstrated new ways of dealing with their child’s symptoms or behaviors.
- If you are working with a significant other as a collateral service, documentation must include how the clinician educated or trained the significant other to better understand or support the client.
- Collateral groups (i.e., parenting groups) are billable with or without the client. The note must reflect how the interventions benefit the client.

MENTAL HEALTH SERVICES – REHABILITATION (3450)

“Rehabilitation” means 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. (CCR Title 9 Division 1, 1810.243) It is important to distinguish “rehabilitation” versus “personal care activities.” Personal care activities are not reimbursable activities. The following graphic shows the distinction between rehabilitation and personal care activities:
It should be noted that Rehabilitative Activities are designed to enable the client to overcome the limitations due to the mental disorder and to teach the client to function in an age appropriate manner without the need for redirection or intervention.

- **ACTIVITIES**
  Rehabilitation activities are usually face-to-face or by telephone with the client and may be provided in the office or in the community. Rehabilitation can be done as:
  - Individual Rehabilitation
  - Group Rehabilitation (for two or more clients)
  - Education, training, and counseling to the client in relation to the following functional skills:
    1. Health – medication education and compliance, grooming and personal hygiene skills, meal preparation skills
    2. Daily Activities – money management, leisure skills
    3. Social Relationships – social skills, developing and maintaining a support system
    4. Living Arrangement – maintaining current housing situation

**PROGRESS NOTES – GROUP REHABILITATION (3570)**
When providing Group Rehabilitation (i.e. two or more clients), the progress note must include the following four items, otherwise it is at risk of disallowance:
1. Type or name of group

2. Total group time, which is the time spent in group plus documentation time and may also include travel time
   - Duration of service in exact minutes
     - Start and Stop times of the direct service
     - Documentation/Travel time

3. Number of clients

4. Number of staff and their names (if there is more than one staff member) with appropriate credentials

**DOCUMENTATION TIP**

*If there are two staff members co-facilitating a group, document the need for more than one facilitator.*

*Progress notes that fail to provide adequate information about the intervention(s) are at risk of disallowance because it may be unclear if the 'Rehabilitation Activity' was provided.*

**MENTAL HEALTH SERVICES – THERAPY (3410, 3412, 3414, 3415)**

“Therapy” means a service activity which 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. (CCR Title 9 Division 1, 1810.250)

For documentation of a therapy note, the interventions must focus on amelioration or reduction of mental health symptoms.

**ACTIVITIES**

Therapy can be face-to-face, or over the telephone, or via telemedicine with the client(s) or family, and may be provided in the office or in the community.

- Individual Therapy
- Group Therapy (for two or more clients)
- Family Therapy with the client present
Therapy can only be provided by an LPHA or a trainee supervised by an LPHA. See the Scope of Practice section for more information.

- **PROGRESS NOTES – GROUP THERAPY (3510)**
  When providing Group Therapy (i.e., two or more clients), the progress note must include the following four items, otherwise it is at risk of disallowance:

  1. Type or name of group
  2. Total group time, which is the time spent in group plus documentation time and may also include travel time
   - Duration of service in exact minutes
   - Documentation/Travel time
  3. Number of clients
  4. Number of clinicians, their names (if there is more than one clinician) with appropriate credentials, and their time spent providing the group service

- **DOCUMENTATION TIP**
  If there are two clinicians co-facilitating a group, document the need for more than one facilitator.

- **DOCUMENTATION TIP**
  Progress notes that fail to provide adequate information about the intervention(s) are at risk of disallowance because it may be unclear if the Therapy activity was provided; i.e., each note must have the problem area/clinical focus, staff intervention and the client’s response. Each note must be unique to the client as well as to an intervention on their client plan.

**TARGETED CASE MANAGEMENT (3030)**

Targeted Case Management (TCM) – Linkage and Brokerage service includes a broad array of services designed to assist and support clients, including life areas that fall outside of the mental health system.

Definition of TCM – Linkage and Brokerage services are 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 (CCR Title 9 Division 1, 1810.249).

- Linkage and Brokerage – Assist clients to access and maintain needed services such as psychiatric, medical, educational, social, prevocational, vocational, rehabilitative, or other community services
- Placement – Assist clients to obtain and maintain adequate and appropriate living arrangements
- Consultation – Exchange of information with others in support of client’s services

**ACTIVITIES**
TCM - Linkage and Brokerage activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. These services may also include contact with other professionals.
- Communicating, consulting, coordinating and corresponding with the client and/or others to establish the need for services and a plan for accessing these services
- Establishing and making referrals
- Monitoring the client’s access to services
- Monitoring the client’s progress once access to services has been established
- Locating and securing an appropriate living arrangement, including linkage to resources; i.e., Board and Care, Section 8 Housing, or transitional living
- Arranging and conducting pre-placement visits, including negotiating housing or placement contracts

**DOCUMENTATION TIP**
Case management does not include transportation solely for the purpose of transportation...or waiting for a doctor’s appointment, waiting at SSI office, completing SSI paperwork....

**PROGRESS NOTES**
A TCM Linkage and Brokerage progress note includes the focus of the assistance/intervention provided to the client (e.g., accessing medical services) and justifies the need for this service based on mental health symptoms/issues; i.e. who was spoken to, what was discussed with professional, what is the plan, is there a referral to an outside service and what is the next step needed to assist the client.

**MISCELLANEOUS**
See Lock-Out Grid **APPENDIX E**
Crisis Intervention is an immediate emergency response that is intended to help the client cope with a crisis (e.g. potential danger to self or others; potentially life altering event; severe reaction that is above the client’s normal baseline, etc.).

Definition – “Crisis Intervention” means 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. Crisis Intervention is distinguished from Crisis Stabilization by being delivered by providers who do not meet the Crisis Stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348. (CCR Title 9 Division 1, 1810.209)

ACTIVITIES
Crisis Intervention activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. These include:

- Assessment of the client’s mental status, acuity of symptoms and current need
- Therapeutic services for the client
- Education, training, counseling, or therapy for significant support persons involved

PROGRESS NOTES
An excellent Crisis Intervention progress note contains a clear description of the “crisis,” in order to distinguish the situation from a more routine event and the interventions used to help stabilize the client.

All services provided (i.e., Crisis Assessment, safety plan, Collateral, Individual/Family Therapy, TCM - Linkage and Brokerage) shall be billed as Crisis Intervention.

- Once the crisis is resolved, any follow-up cannot be billed as Crisis
- The maximum amount claimable to Medi–Cal for crisis intervention in a 24-hour period is 8 hours (480 minutes) per client

DOCUMENTATION TIP
Two people cannot bill crisis simultaneously on one client when the purpose of the presence of the other staff member is purely for safety reasons.
“Medication Support Services” means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to development related to the delivery of the service and/or assessment of the beneficiary (CCR Title 9 Division 1, 1810.225).

**CAUTION:** These symptoms should be related to the client’s documented diagnosis.

### ACTIVITIES

Medication Support Services activities are usually face-to-face or by telephone with the client or significant support persons and may be provided in the office or in the community. These services include:

- Evaluation of the need for psychiatric medication
- Evaluation of clinical effectiveness and side effects of psychiatric medication
- Medication education, including discussing risks, benefits and alternatives with the client or support persons
- Ongoing monitoring of the client’s progress in relation to the psychiatric medication
- Prescribing, dispensing, and administering of psychiatric medications
- The maximum amount claimable to Medi-Cal for medication support services in a 24-hour period is 4 hours (240 minutes) per client
1. Assessing
   - Assessing client’s and family’s needs and strengths
   - Assessing the adequacy and availability of resources
   - Reviewing information from family and other sources
   - Evaluating effectiveness of previous interventions and activities

2. Service Planning and Implementation
   - Developing a plan with specific goals, activities, and objectives
   - Ensuring the active participation of client and individuals involved and clarifying the roles of individuals involved
   - Identifying the interventions/course of action targeted at the client’s and family’s assessed goals

3. Monitoring and Adapting
   - Monitoring to ensure that identified services and activities are progressing appropriately
   - Changing and redirecting actions targeted at the client’s and family’s assessed needs, not less than every 90 days

4. Transition
   - Developing a transition plan for the client and family to foster long term stability including the effective use of natural supports and community resources

Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members

Pathways to Mental Health Services – Core Practice Model (CPM) Guide

KATIE A SUBCLASS – MENTAL HEALTH SERVICES – INTENSIVE HOME-BASED SERVICES (3230)

Intensive Home-Based Services (IHBS) are intensive, individualized and strength-based, needs-driven intervention activities that support the engagement and participation of a child/youth and his/her significant support persons and to help the child/youth develop skills and achieve the goals and objectives of the client plan. IHBS are not traditional therapeutic services. This service is targeted to the Katie A. Subclass (and their significant support persons). Services are expected to be of significant intensity to address the intensive mental health needs of the child/youth, consistent with the client plan and the Core Practice Model. Services may be
delivered in the community, school, home or office settings. IHBS services includes, but not limited to:

- Medically necessary skill-based interventions for the remediation of behaviors or improvement of symptoms
- Development of functional skills to improve self-regulation or self-care
- Education of the child/youth/family/caregiver about how to manage the clients’ symptoms
- Support of the development, maintenance and use of social networks and community resources
- Support to address behaviors that interfere with the achievement of a stable and permanent family life and stable housing, obtain and maintain employment and achieving educational objectives

MENTAL HEALTH SERVICES – THERAPEUTIC BEHAVIORAL SERVICES (3230)

Therapeutic Behavioral Services (TBS) are supplemental specialty mental health services under the EPSDT benefit. TBS is an intensive, individualized, one to one, short-term, outpatient treatment intervention for clients up to age 21 with Serious Emotional Disturbances (SED) who are experiencing a stressful transition or life crisis that is placing the individual at risk of an out of home placement in a RCL 12 or higher or are at risk of a psychiatric emergency. TBS is also used to help a client transition from this high level of care (RCL 12 group home or psychiatric hospital to a lower level of care.

- **ACTIVITIES**
  
  TBS activities are usually face-to-face with the client and can be provided in most settings. TBS-related activities can also be provided to significant support persons in collaboration with other professionals.

  - One-to-one therapeutic contact typically models/teaches, trains or supports appropriate behavioral changes
  - TBS activities may also include assessment, collateral, and plan development, which are coded as TBS
  - TBS is provided only by qualified providers (see Scope of Practice grid)
SERVICES & DESCRIPTIONS PERTAINING TO MEDICAL STAFF

1. MEDICATION EVALUATION
   For Prescribers only:
   - This service is used when a psychiatric assessment is performed by a Prescriber

2. MEDICATION MANAGEMENT
   For Prescribers only:
   - Includes clinic visits, refilling prescriptions, face-to-face or telephone consults with other Medical Prescribers

3. MEDICATION SUPPORT NON-PRESCRIBERS
   For Medical Staff Non-Prescribers (Registered Nurses, Licensed Vocational Nurses & Licensed Psychiatric Technicians)
   - Administering of medication per Prescriber’s orders
   - Evaluation of clinical effectiveness and side effects of psychiatric medication
   - Ongoing monitoring of the client’s progress in relation to the psychiatric medication
   - Medication education, including discussing risks, benefits and alternatives with the client or support persons

4. PSYCHIATRIST, PRESCRIBERS AND ALL MEDICAL STAFF NON-PRESCRIBERS (see above) CAN ALSO PROVIDE:
   - Medication Injection
   - Prep report other Physicians/Agency (Preparation of report for other physicians/agencies)
   - Review Hospital Records/Reports/Labs (Review of hospital records, reports and labs)

CAUTION: Aside from Medication Support Services, all medical staff may also provide Plan Development, TCM-Linkage and Brokerage or Crisis Intervention as needed.
IX. NON-REIMBURSABLE SERVICES

For Medi-Cal, some services are not eligible for reimbursement, even though they may be provided on behalf (and to the benefit) of the client. These non-reimbursable services include, but are not limited to, the following:

- Academic educational services
- Vocational services which have as a purpose actual work or work training
- Recreation
- Personal care services provided to clients (e.g. grooming, personal hygiene, assisting with medication, preparation of meals, etc.)
- Socialization if it consists of generalized group activities which do not provide systematic individualized feedback to the specific target behaviors of the clients involved
- Transportation of a client
- Service provided solely payee related
- Translation/interpretation services
- Missed appointments
- Travel time when no face-to-face contact with the client or significant support person was provided, including leaving a note on the door for the client
- Leaving and/or listening to telephone messages
- Communication via e-mail unless clinically appropriate (e.g., therapeutic communication for deaf and hard-of-hearing clients)
- Completing mandatory reports: CSD, APS, Tarasoff, etc., including making associated phone calls
- Completing Social Security reports
- Clerical tasks: faxing, copying, mailing, etc.
- After the death of a client, no services are billable

- Supervision in which the primary purpose is for the benefit of the clinician, which includes trainees and student interns. Regularly scheduled supervision time would not be reimbursable, even though the client’s care may be discussed.
- Staff development activities, including conferences, workshops, trainings, reading literature, Internet searches, etc.
- Preparation for a service activity, such as collecting materials for a group session
- Cleaning the office/play therapy room after client leaves

**DOCUMENTATION TIP**

While the above services are non-billable, some of these activities should be documented using the 4010 informational note code or 4000 no show code.
A “lockout” means that a service activity is not reimbursable through Medi-Cal because the client resides in and/or receives mental health services in one of the settings listed below. A clinician may provide the service (e.g. targeted case management for a client residing in an IMD), but it would be reimbursable only under certain circumstances – See Lock–Out Grid in APPENDIX E.

- Jail/Prison
- Juvenile Hall (not adjudicated)
- Institute of Mental Disease (IMD)

No service activities are reimbursable if the client resides in one of these settings (except for the day of admission & discharge):

- Psychiatric Inpatient
- Psychiatric Nursing Facility

  **Exception:** Medication Support Services or TCM-Linkage and Brokerage (for placement purposes only within 30 days of discharge) are reimbursable

No other service activities are reimbursable if the client resides in one of these settings (except for the day of admission & discharge):

- Crisis Stabilization

No other service activities are reimbursable during the same time period that the client is at the Crisis Stabilization Unit (Except for the day of admission and discharge, before or after).

  **Exception:** Targeted Case Management *for placement purposes only* is reimbursable while client is at the Crisis Stabilization Unit

**INTENSIVE CARE COORDINATION**

- For members of the target group who are transitioning to a community setting ICC services will be made available for up to 30 calendar days for a maximum of three non-consecutive periods of 30 calendar days 25 or less per hospitalization or inpatient stay prior to the discharge of a covered stay in a medical institution. The target group does
not include individuals between ages 22 and 64 who are served in an IMD or individuals who are inmates of public institutions. ICC may be provided solely for the purpose of coordinating placement of the child/youth on discharge from the hospital, psychiatric health facility, group home or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility as part of discharge planning.

**INTENSIVE HOME-BASED SERVICES**

- Mental health services (including IHBS) are not reimbursable when provided by day treatment intensive or day rehabilitation staff during the same time period that day treatment intensive or day rehabilitation services are being provided. Authorization is required for mental health services if these services are provided on the same day that day treatment intensive or day rehabilitation services are provided. IHBS may not be provided to children/youth in Group Homes. IHBS can be provided to children/youth that are transitioning to a permanent home environment to facilitate the transition during single day and multiple day visits outside the Group Home setting. Certain services may be part of the child/youth’s course of treatment, but may not be provided during the same hours of the day that IHBS services are being provided to the child/youth. These services include:
  - Day Treatment Rehabilitative or Day Treatment Intensive
  - Group Therapy
  - Therapeutic Behavioral Services (TBS)
  - Targeted Case Management (TCM)

**DOCUMENTATION TIP**

Standard Skilled Nursing Facility (SNF) is NOT a lock-out environment; only a Skilled Psychiatric Nursing Facility would be a lock-out. A Skilled Nursing Psych Facility requires more than 50% of the beds to be “psych” beds.
XI. DOCUMENTATION EXAMPLES

Each of these documents will provide an example for how to properly fill out various forms related to the previous sections. All individuals highlighted in these following examples are fictitious and have been created for the sole purpose of providing examples. There are 2 sections of examples: adult examples and youth examples. Examples will be listed in the order they appear in the list below. Each title is clickable and will take you to the desired documentation example. If you want to return from the documentation example to the adult or youth lists below, click the small banner next to the name of the example.

ADULT EXAMPLES

INFORMED CONSENT

NOTICE OF PRIVACY PRACTICES

GUIDE TO MEDI-CAL MENTAL HEALTH SERVICES

INITIAL ASSESSMENT

MENTAL STATUS EXAM

MEDICAL NECESSITY DETERMINATION

DIAGNOSIS REPORT

TREATMENT (TX) PLAN

PROGRESS NOTE – ASSESSMENT(3310)

PROGRESS NOTE – CRISIS(3715)

PROGRESS NOTE – REHABILITATION(3450)

PROGRESS NOTE – BROKERAGE MEDICAL APPOINTMENT(3030)

PROGRESS NOTE – MEDICAL(3630)

PROGRESS NOTE – BROKERAGE PHONE CALL(3030)

PROGRESS NOTE – PLAN DEVELOPMENT(3910)

PROGRESS NOTE – REHABILITATION GROUP(3570)

DISCHARGE DIAGNOSIS

DISCHARGE REPORT
YOUTH EXAMPLES

INFORMED CONSENT

NOTICE OF PRIVACY PRACTICES

GUIDE TO MEDI-CAL MENTAL HEALTH SERVICES

INITIAL ASSESSMENT

MENTAL STATUS EXAM

DIAGNOSIS REPORT

MEDICAL NECESSITY DETERMINATION

YOUTH TREATMENT (TX) PLAN

PROGRESS NOTES – ASSESSMENT(3310)

PROGRESS NOTES – PLAN DEVELOPMENT(3910)

PROGRESS NOTES – INDIVIDUAL(3412)

PROGRESS NOTES – COLLATERAL(3110)

PROGRESS NOTES – REHABILITATION(3450)

PROGRESS NOTES – PLAN DEVELOPMENT(3910)

PROGRESS NOTES – INFORMATIONAL NOTE(4010)

PROGRESS NOTES – BROKERAGE(3030)

PROGRESS NOTES – COLLATERAL(3110)

PROGRESS NOTES – COLLATERAL GROUP(3112)

PROGRESS NOTES – KATIE A – INTENSIVE CARE COORDINATION(3040)

PROGRESS NOTES – KATIE A – INTENSIVE HOME BASED SERVICES(3420)
BCDBH - Informed Consent for Services
For (75965) SIMPSON, BARTHOLOMEW
Episode # 1
Final

Services:
I understand that all services are voluntary. I have the right to be informed about services to participate in their selection, and to withdraw this consent at any time, except to the extent that action has already been taken. Services include assessment, and may also include individual, group, family, and multifamily counseling; case management; medications; crisis intervention; recreational and vocational therapy; parent education; and independent living skills. Acceptance and participation in these services shall not be considered a prerequisite for access to other community services. I have the right to request a change of provider, staff person, therapist, and/or case manager.

Confidentiality:
I understand that my relationship with Butte County Department of Behavioral Health is confidential unless I give written permission to release information to a specific source, except in certain life and death emergencies or by court order. I also understand that if a staff person seriously believes that I intend to harm others, or myself, or suspects child or elder abuse/neglect, s/he is legally and ethically bound to report this information to the appropriate authorities.

Contract for Services:
I understand that I am responsible for cooperating with my clinician/case manager, and for keeping my appointments or calling to cancel them in a timely manner. I understand that if I am more than ten minutes late for a group, I may not be admitted into the group. I also understand that if I fail to follow through with my treatment, my case may be closed.

I Have Read and Understand the Above Statements and Give my Consent for Treatment.
Unless I withdraw my consent earlier, this consent will expire one year from the date of my signature. I have the right to receive a copy of this document. I reserve all rights provided to me by law not waived by the scope of this consent and authorization.

<table>
<thead>
<tr>
<th>Copy of informed consent offered?</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member information offered?</td>
<td>Yes</td>
</tr>
<tr>
<td>Advanced Directive Info Sheet offered (Adults only)?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Signature(s)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIMPSON, BARTHOLOMEW</td>
<td>1/5/2015</td>
</tr>
</tbody>
</table>

This consent was originally obtained by:

(041932) JEFFERY, JOANN

Client Signature

Required Signature(s):

<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>JEFFERY, JOANN (041932) - BH Clinician, LMFT</td>
<td>1/5/2015</td>
</tr>
</tbody>
</table>

Date of Consent: 1/5/2015

BCDBH Informed Consent
Ver 1.3 12/5/2014

Confidential Patient information
See California Welfare and Institutions Code Section 5328

SIMPSON, BARTHOLOMEW
Client Name
75965
Client Number
Acknowledgement of the Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practices from the Butte County Department of Behavioral Health.

Signed: ____________________________ on this date: 1/5/2015

Client Signature

Required Signature(s):

______________________________ 1/5/2015

JEFFERY, JOANN (041932) - BH
Clinician, LMFT

Confidential Patient Information
See California Welfare and Institutions Code Section

75985
Client Number
SIMPSON, BARTHOLOMEW
Client Name
Acknowledgement of Receipt of the Guide to Medi-Cal Mental Health Services

For (75985) SIMPSON, BARTHOLOMEW Program: 40111 CH MH Adult OP
Episode Number: 1 Draft/Final: Final
Date: 1/5/2015

Client DID receive a copy of the guide to Medi-Cal Mental Health Services. ___ Yes ___

Required Signature(s):

JEFFERY, JOANN (041932) - BH Clinician, LMFT

Date: 1/5/2015

Confidential Patient Information See California Welfare and Institutions Code Section 5328

SIMPSON, BARTHOLOMEW
Client Name
75985
Client Number

Acknowledgement of MMHS Ver 1.2 12/8/2014
Behavioral Health Clinical Assessment of SIMPSON, BARTHOLOMEW
Episode #1  Program: 40111CH MH Adult OP
Run Date: 1/5/2015  Assessment Date: 1/6/2015
Assessing Clinician: (041932) JEFFERY JOANN
Assessment Type: Initial Final
Next Assessment Due: 1/4/2016
Referred by: Psychiatric Hospital
Referral Source: Client, Law Enforcement, Medical Professional, Other
Other Source of Information: Out of County Hospitalization Records

Clinical Assessment of SIMPSON, BARTHOLOMEW
Assessing Clinician: (041932) JEFFERY JOANN
Episode #1  Program: 40111CH MH Adult OP
Assessment Date: 1/5/2015  Assessment Type: Final

Client Demographic Data:
DOB: 5/1/1970  Age at Assessment: 44 years  Gender: Male  Education: 13 Years
Living Arrangements: Board And Care
Martial Status: No Entry  Employment: Not In Labor Force - Unable To Work D
Primary Language: English  Smoker: Current Every Day Smoker  Ethnicity/Race: White

Presenting Problems Past and Present

General Appearance:
Mr. Simpson is a tall, slender, middle aged man. He wore a heavy jacket, over several other shirts and sweaters, despite the 90 degree weather outside. Mr. Simpson's clothing was dirty and stained. Mr. Simpson's hair was uncombed, he is unshaven, and has a strong body odor. Mr. Simpson's fingernails were long and dirty.

Presenting Problems, History, Duration of Presenting Symptoms, Precipitating Events and Stressors:
Mr. Simpson was referred to outpatient services after being discharged from a 24 day stay on the PHF. Mr. Simpson was hospitalized after being brought to Crisis Services by Chico P.D. Mr. Simpson reportedly struck an elderly woman in his apartment complex, and continues to complain, "That damn bitch. She and the rest of them deserved more than that for what they have put me through." Mr. Simpson is a 44-year-old, single, unemployed white man. He has been continuously ill since the age of 22 while during his first year of college he became convinced his classmates were making fun of him. His academic performance declined and he was asked to leave the school and seek psychiatric care. Bart was able to get a job in a retail store; however after 7 months he was fired after his behavior became too bizarre and he was unable to do the tasks required of him. Shortly after this time Bart was hospitalized for the first time and reported hearing voices. The most recent hospitalization was number 13 and Bart has not been able to work since he was fired over 20 years ago. Bart is very socially isolated and believes his apartment is the center of a large communication system involving several major television networks. He maintains there are secret cameras in his apartment that record his behaviors and when he watches TV he states the announcer comments on these behaviors. Bart presents with paranoia, delusions, difficulty sleeping, and continued voices.

Client History and Information

Educational History:
Mr. Simpson graduated from high school and began college, but was unable to complete his first year. Mr. Simpson reports that he had good grades in high school, but was asked to leave the school because his grades declined drastically after he became convinced that his classmates were making fun of him. He reports they would snort and sneeze when he entered the classroom.

Employment History:
Mr. Simpson was employed for 7 months at a retail store; however he reports he was getting a number of distracting "signals" from his co-workers and he became more and more suspicious and withdrawn. It was also at this time that he first reported hearing voices. Mr. Simpson was fired at this time and has been unable to work since.

Client's Cultural/Spiritual Belief and Family Background:
Mr. Simpson states he was brought up in a white, middle class family. His father was an attorney and his mother was a homemaker. Bart did not identify a religious preference. He stated he has brothers and sisters, but became suspicious when I asked about them and whether he has contact. Mr. Simpson said he believes his mother suffered from anxiety and that he his paternal grandmother was hospitalized for "mental problems". Mr. Simpson said his dad was strict, but not abusive.
Clinical Assessment of (75985) SIMPSON, BARTHOLOMEW
Assessing Clinician: JEFFERY, JOANN
Assessment Date: 1/5/2015
Assessment Type: Final
Episode #: 1
Program: (40111) CH MH Adult OP

Social and Relationship History (include current or past legal issues and sexuality):
Mr. Simpson had a girlfriend while he was attending college, but she broke up with him and he thought she had been kidnapped.
Mr. Simpson doesn’t currently have any friends and keeps to himself inside his apartment. He states he enjoys reading the Wall Street Journal Daily. He does not trust people and states, “everyone is out to get me and that is why I don’t leave my apartment very often”. Mr. Simpson has charges pending from hitting his elderly neighbor; however she may drop the charges now that she has learned Bart was most likely suffering from an unmanaged mental illness. Mr. Simpson states there is a machine operated by his neighbors called the “dream machine” and they put erotic dreams into his head.

Does Substance Use Interfere/Exacerbate MH Problems:
No

Please Describe:
Mr. Simpson states he drinks coffee in the morning and smokes 2 packs of cigarettes a day. He does not use illicit drugs and reports he never has used drugs. He has drank occasionally in the past, but reports he has never been drunk.

Mental Health Treatment History (include psychiatric hospitalizations and family psychiatric history):
13 mental health hospitalizations since age 24, the longest lasting 8 months. Mr. Simpson usually stabilizes on medication, but once back out in the community he stops taking his medication and refuses to come in for treatment. Mr. Simpson reports he did not have these behaviors as a child, but believes his family is angry with him for not finishing school which is why they don’t have contact with him now.

Medical Issues:
Yes

Please explain Medical Issues:
Mr. Simpson coughs frequently and reports he has not seen a doctor for this. Mr. Simpson may also be nutritionally compromised as when he was brought in to the PHF, there was no food in the home and Mr. Simpson has not been able to communicate what and when he eats.

Life Threatening Allergies:
Unknown

Prescribed Medications: (for psychiatric and medical conditions, include OTC medications)
Mr. Simpson says he is supposed to take a multivitamin daily, but thinks this is where the government hides transmitters so he doesn’t take them. Mr. Simpson has a well documented history of poor med compliance. At the PHF he was prescribed zyprexa injections to manage his psychotic symptoms and trazadone for sleep. It is unknown if Mr. Simpson has taken the Trazadone since being D/C’d from the PHF; however, BCDBH staff report Bart was ready and waiting when they came to transport him for his injection appointment.

Medication Allergies/Adverse Reactions:
NKDA

Clinical Formulation

Date of Medical Necessity Determination:
Jan 05 2015 - Jeffery, Joann

Date of Mental Health Exam:
Jan 05 2015 12:00AM - Jeffery, Joann

Service Needs/Recommendations:
Mr. Simpson is in need of ongoing case management and medication services. He would also benefit from increased socialization. Will work with case management staff for linkage and brokerage, as well as rehab services. Will make a referral for medication services. Explore options for increasing socialization, wellness, and continued stabilization.
Presenting Problems #1:

Mr. Simpson is at risk of losing his current living environment due to striking a neighbor.

Client Strengths in Addressing Problem:

Mr. Simpson states he likes where he is living and does not want to move.

Presenting Problems #2:

Mr. Simpson stops taking his medication when he is discharged from the hospital.

Client Strengths in Addressing Problem:

Mr. Simpson wants to feel more calm.

Presenting Problems #3:

Mr. Simpson is very socially isolated.

Client Strengths in Addressing Problem:

Mr. Simpson states it would be nice to have someone he could trust to talk with.

Initial Assessment Originally Completed by: (041932) JEFFERY, JOANN

I pulled forward the BCDBH Initial Assessment and did not make any changes: N/A
Behavorial Health Mental Status Exam

For (75983) SIMPSON, BARTHOLOMEW

Program: (40111) CH MH Adult OP

Run date: 1/5/2015

Assessing Clinician: (041932) JEFFERY, JOANN

Mental Status Exam Type: Final

Mental Status Exam Date: 1/5/2015

General Appearance

Dress: Unkempt, Dirty
Facial Expressions: Worried, Avoids Gaze, Preoccupied
Grooming: Dirty, Un-bathed, Body Odor
Body Size: Tall, Thin

Psychomotor Behavior

Gait: Slow, Hesitant
Abnormal Movements: None
Posture: Stiff, Erect
Rate of Movement: Slowed
Coordination of Movmt: Awkward

Mood / Affect

Range of Affect: Blunted
Interview Behavior: Angry, Irritable, Sensitive, Evasive
Mood: Anxious

Mood / Affect Comments:
Mr. Simpson became angry about the reason he was hospitalized, but calmed quickly when I validated his feelings and offered support. He was evasive in talking about parts of his family history and asked if we could discuss this another day.

Speech

Rate of Speech: Slow, Hesitant, Rambling
Intensity of Volume: Soft, Whispered
Clarity: Clear, WNL
Quality: WNL
Quantity: Responds only to questions, Repetitive

Speech Comments:
Mr. Simpson would begin to answer a question and would trail off and begin talking about an unrelated topic. At times he would repeat my questions several times before answering. He spoke very softly and at times would whisper because “they can hear us you know”.

Cognition

Attn/Concentration: Variable, Distractible, Preoccupied
Memory: Short Term Average, Remote Average
Abstraction: Bizarre
Insight: Blames Others, Unrealistic Regarding Degree of Illness
Orientation: Person, Situation
Judgment: Impulsive, Fair
Intellect: Average
Mental Status Exam For: (75985) SIMPSON, BARTHOLOMEW  
Assessing Clinician: (041932) JEFFERY JOANN -  
Mental Status Exam Type: Final  
MSE Date: 1/5/2015  
Episode # 1

### Thought Patterns

<table>
<thead>
<tr>
<th>Clarity of Thought</th>
<th>Vague</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevance</td>
<td>Illogical, Irrelevant</td>
</tr>
<tr>
<td>Flow of Thought</td>
<td>Flight of ideas, Loose Association</td>
</tr>
<tr>
<td>Content of Thought</td>
<td>Suspiciousness, Persecuted, Blames Others</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>Mood Congruent, Auditory</td>
</tr>
<tr>
<td>Illusions</td>
<td>Not Present</td>
</tr>
<tr>
<td>Delusions</td>
<td>Of Persecution, Of Being Controlled</td>
</tr>
<tr>
<td>Suicide</td>
<td>None, Risk Low</td>
</tr>
<tr>
<td>Homicide</td>
<td>Transient, Risk Low</td>
</tr>
</tbody>
</table>

Thought Patterns Comments:
Mr. Simpson vacillates between believing his neighbor deserved to get hurt and recognizing being assaultive isn’t appropriate.

### Level of Consciousness

| Lvl of Consciousness | Lethargic |

Required Signature(s):

JEFFERY, JOANN (041932) - BH Clinician, LMFT  
01/05/2016  
Licensed Clinician Signature  
Date

This MSE was originally completed by:  
041932 JEFFERY, JOANN

I pulled forward the BH Mental Status Exam and did not make any changes  
N/A
**Presenting Problem:**

Mr. Simpson was initially referred to outpatient services after being discharged from a 24 day stay on the PHF. Mr. Simpson was hospitalized after being brought to Crisis Services by Chico P.D. Mr. Simpson reportedly struck an elderly woman in his apartment complex, and continues to complain, "That damn bitch. She and the rest of them deserved more than that for what they have put me through." Mr. Simpson is a 44-year-old, single, unemployed white man. He has been continuously ill since the age of 22 while during his first year of college he became convinced his classmates were making fun of him. His academic performance declined and he was asked to leave the school and seek psychiatric care. Bart was able to get a job in a retail store; however after 7 months he was fired after his behavior became too bizarre and he was unable to do the tasks required of him. Shortly after this time Bart was hospitalized for the first time and reported hearing voices. The most recent hospitalization was number 13 and Bart has not been able to work since he was fired over 20 years ago. Bart is very socially isolated and believes his apartment is the center of a large communication system involving several major television networks. He maintains there are secret cameras in his apartment that record his behaviors and when he watches TV he states the announcer comments on these behaviors. Bart presents with paranoia, delusion, difficulty sleeping, and continued voices.

<table>
<thead>
<tr>
<th>Impairment Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Living Arrangement/Housing:</strong></td>
</tr>
<tr>
<td>Probability of Deterioration:</td>
</tr>
<tr>
<td>Explain: Bart has been able to maintain a stable living environment with the help of section 8; however, he may lose his current living environment if his symptoms are not better managed. The apartment manager states that Bart's outbursts toward elderly neighbors have become a liability.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activities of Daily Living:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Impairment:</td>
</tr>
<tr>
<td>Explain: Mr. Simpson does not appear to adequately attend to hygiene or grooming. Mr. Simpson reports he has not been showering because the voices are worse when he closes the shower curtain.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Support Group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Impairment:</td>
</tr>
<tr>
<td>Explain: Bart only sees his uncle twice a year and has no other contacts or social supports.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently not an issue</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Economic Issues:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Impairment:</td>
</tr>
<tr>
<td>Explain: Mr. Simpson often loses track of his SSI funds and often doesn't have money to pay his monthly bills. When asked about where he spends his money, Mr. Simpson replied, &quot;The government must be taking it because I only buy tobacco and roll my own.&quot; Mr. Simpson also added the government is using his money to cover the cost of his surveillance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access to Health Care Services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Impairment:</td>
</tr>
<tr>
<td>Explain: Bart has not followed up with mental health treatment until now because he believes service providers are plotting against him.</td>
</tr>
</tbody>
</table>

---

**Behavioral Health Medical Necessity Determination**

**for (75086) SIMPSON, BARTHOLOMEW  Episode# 1  Admit Date: 1/5/2016  (40111) CH MH Adult OP**

**MND Date: 1/5/2015  Evaluator: 041932  Report Date: 1/5/2015**

**MND Type: Initial  Draft/Final: Final**

---

**SIMPSON, BARTHOLOMEW**

**Client Name  75086**

**Client Number**
Medical Necessity Determination Continued

Social Relationship/Environment/Community:

<table>
<thead>
<tr>
<th>Significant Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain: Bart is paranoid, maintains he is being watched by neighbors and people on the streets and that others are controlling him.</td>
</tr>
</tbody>
</table>

School Situation:

Currently not an issue

<table>
<thead>
<tr>
<th>Service Indicators</th>
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<table>
<thead>
<tr>
<th>Substance Use:</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Victim related trauma:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Briefly explain victim related trauma:

Mr. Simpson was not in the condition to give historical data about his past history.

<table>
<thead>
<tr>
<th>Suicidal/Self Harm - Current:</th>
</tr>
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<tbody>
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<table>
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<th>Suicidal/Self Harm - Past:</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Homicidal/Danger to Others - Current:</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Homicidal/Danger to Others - Past:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideation, Intent, Plan, Means</td>
</tr>
</tbody>
</table>

Comments:

Mr. Simpson recently assaulted his elderly neighbor and has an upcoming court date. Mr. Simpson verbalized that he should not have hit his neighbor and that he no longer feels this way about her, despite earlier stating she deserved it.

<table>
<thead>
<tr>
<th>Medical Necessity</th>
</tr>
</thead>
</table>

Primary DSM-IV Diagnosis that will be the focus of the intervention provided.

Provisional Diagnosis: (3)Schizophrenia/psychotic disorder.

Client must have at least one of the following impairments:

☐ A probability of significant deterioration in an important area of life functioning.
☐ A significant impairment in an important area of life functioning.
☐ Child will not progress developmentally as individually appropriate.
☐ Not Applicable.

Client must have at least four of the intervention criteria:

☐ Child won’t develop as individually appropriate.
☐ Client will benefit from intervention.
☐ Condition will not respond to primary health care alone.
☐ Intervention focuses on functional impairment.
☐ Prevent deterioration in life function.
☐ Significantly diminish the functional impairment.
☐ Treatment intervention not applicable.

Client’s condition is expected to be responsive to Specialty Mental Health Services? Yes
Scheduled Assessment? Yes
Staff scheduled for intake assessment: 
Do you have a Primary Physician? Yes
Name of Primary Care Physician: AMPLA
Where did you refer client for Primary Care Services? 
Referral Made:

Date and Time: 1/5/2015 at 02:35 PM
NOA Given? No
Was Medical Necessity Met? Yes
Medical Necessity Determination Continued

Substance Use History

Caffeine: Current Use
Alcohol: None
Tobacco: Current Use
Cannabis: None
OTC/Complimentary/Alternative Medication: None
Prescription: None
Illicit Drugs: None
Other: None

Substance-related diagnosis indicated? No

Comments (support diagnosis if applicable):

I pulled forward the Medical Necessity Determination and did not make any changes.

Required Signature(s):

JEFFERY, JOANN (041932) - BH Clinician, LMFT
1/5/2015 Date

Initial Assessment Originally Completed by: JEFFERY, JOANN

Page 4 of 4

BCDBH Medical Necessity Determination
Confidential Patient Information
Version 1.5 DEV 12/2/2014
See California Welfare and Institutions Code Section 8328

SIMPSON, BARTHOLOMEW
Client Name
75985 Client Number
ADULT DIAGNOSIS REPORT

Behavioral Health Client Diagnosis Report
for (75985) SIMPSON,BARTHOLOMEW Program: (40111) CH MH Adult OP
Run Date: 1/5/2015
Diagnosing Clinical Staff: (041932) JEFFERY,JOANN
Diagnosis Type: Admission - Final

AOD Diagnosis?: No

Diagnosis Date and Time: 1/5/15 01:51 PM Episode: 1

Primary Diagnosis: 295.32 "SCHIZOPHRENIC DISORDER, PARANOID TYPE, CHRONIC"

Axis I - Primary 295.32 "SCHIZOPHRENIC DISORDER, PARANOID TYPE, CHRONIC"
Axis I - Secondary
Axis I - Tertiary
Axis I - (4)
Axis I - Provisional
Axis II(1)
Axis II(2)
Axis II - Provisional
Axis III(1)
Axis III(2)
Axis III - Other

Chronic cough & poor nutrition

Axis IV
Primary Support Group: Yes
Social Environment: Yes
Education: No
Occupation: Yes
Housing: Yes
Economic: Yes
Health Care: No
Legal: Yes
Other: No

Axis V
12 Mo High
12 Mo Low

Personality Features #1:
Personality Features #2:

Clerical Data Entry of CSI Data:
CSI Information:
Trauma: Unknown Substance Abuse / Dependence: No

General Medical Condition Summary Code:
Other

JEFFERY,JOANN (041932) 1/5/2015
BH Clinician, LMFT

This diagnosis was originally completed by: 041932, JEFFERY,JOANN

Client Diagnosis Report
Version 1.9 12/10/2014

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SIMPSON,BARTHOLOMEW
Client Name
75985
Client Number

Confidential Patient Information
See California Welfare and Institutions Code Section 5328

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Behavioral Health Client Diagnosis Report
for (75985) SIMPSON,BARTHOLOMEW  Program: (40111) CH MH Adult OP
Run Date: 1/6/2015
Diagnosing Clinical Staff: (041032) JEFFERY,JOANN
Diagnosis Type: Admission - Final

AOD Diagnosis?: No

I pulled forward the BCDBH Diagnosis and did not make any changes  N/A
Behavioral Health Client Treatment Plan
for SIMPSON, BART, Episode #2
Program: CHMH ADULT OP

Plan Date: 1/6/15
Plan End Date: Last date updated: 1/6/15
Plan Name: CAS
Last updated by: JEFFERY, JOANN

PROBLEM: Mr. Simpson stops taking his medication when he is discharged from the hospital.

Assigning Staff: JEFFERY, JOANN
Status: Treat
Responsible Staff: JEFFERY, JOANN

Goal: I want to stay in my apartment

Strengths: Prior to his recent hospitalization Mr. Simpson had lived in his current apartment for the past 5 years.

Obstacles: Mr. Simpson is not aware that his psychotic symptoms are increasing.

Objective: Mr. Simpson will decrease incidents of striking others from 2 times per month to 0 times per month.

Duration: 12 Months
Frequency: weekly
Intervention: Group or individual rehabilitation services to teach, model and encourage the use of coping skills.

Medical Intervention: Medication services (duration and frequency TBD by medical staff) to educate client regarding common psychotic symptoms.

PROBLEM: Mr. Simpson is at risk of losing his current living environment due to striking a neighbor

Assigning Staff: JEFFERY, JOANN
Status: Treat
Responsible Staff: JEFFERY, JOANN

Goal: I would like to have a friend.

Strengths: Mr. Simpson thinks it would be nice to have a friend. Mr. Simpson said he likes making things, music, and fishing.

Obstacles: Mr. Simpson is paranoid at times and has difficulty trusting others.

Objective: Mr. Simpson will engage in 1 social activity per week; currently Mr. Simpson doesn’t engage in any activities outside of his home.

Duration: 12 Months
Frequency: weekly
Intervention: Individual or group rehab to teach, model and encourage the use of appropriate social skills.

Duration: 12 Months
Frequency: bi-monthly
Intervention: Individual therapy to acknowledge Mr. Simpson’s full experience of psychotic symptoms while affirming his past successes in dealing with psychotic symptoms.

Medical Intervention: Medical Staff will encourage patient to appropriately utilize community health resources.

Duration: 12 Months
Frequency: bi-monthly
Intervention: Targeted case management services to connect Mr. Simpson to peer support resources involving others engaged in maintaining efforts to deal with improved social participation.

Report Run Date: 4/17/2015
Client Treatment Plan
Version 2.3 12/17/2014

CONFIDENTIAL PATIENT INFORMATION
See California Welfare and Institutions Code Section 5128

SIMPSON, BART
Client Name: 75985
Client Number: 015669-5128
PROBLEM: Mr. Simpson is at risk of losing his current living environment due to striking a neighbor.

Assigning Staff: JEFFERY, JOANN  
Responsible Staff: JEFFERY, JOANN

STATUS: Treat

GOAL: I want to stay out of the hospital.

STRENGTHS: For the first time Mr. Simpson is open to injectable medications.

OBSTACLES: When Mr. Simpson starts to feel better he stops taking his medication.

OBJECTIVE: Mr. Simpson will have 0 inpatient stays in the next 6 months. Mr. Simpson has had 1 hospitalization in the past month.

Is this an Integrated Intervention? Yes

Duration: 12 Months  
Frequency: 1-3x quarterly

INTERVENTION: Staff will monitor Mr. Simpson for changes in symptomology or indication of non-compliance and will provide medication support to assist Mr. Simpson in identifying a system to help him remember to take his medication and keep his appointment for injections.

MEDICAL INTERVENTION: Medical staff will provide psycho-education regarding early warning signs, signs that things are breaking down, and signs of crisis in relation to clients psychotic symptoms.
Signature of Parent/Guardian

Signature of Client (75985) SIMPSON, BART
Client helped develop, understands, agrees with the goals, and has been offered a copy of this client plan.

If no signature, see progress note dated:

Signature of Staff

Signature of Licensed / Waivered Staff

Psychiatrist Signature

Participants: JEFFERY, JOANN (041932) - BH Clinician, LMFT
HEIBEL-MEIRE, CHARLA (042333) - BH Clinician, LMFT

The Client Treatment Plan was originally completed by: (041032) JEFFERY, JOANN
Behavioral Health Progress Note
For (75985) SIMPSON, BART
Run Date: 1/8/2015

Service Date: 1/5/2015 Draft/Final Note: Final  Note Category: New Service

Patient Name: SIMPSON, BART 75985  Date of Service: 1/5/2015  Episode: 1
Admit Date: 1/5/2015 Discharge Date: 1/5/2015
Written By: JEFFERY, JOANN (041932) - BH Clinician, LMFT Written On: 1/5/2015
Note Time: 03:51 PM

Episode: 1

Program service was provided from: CH MH Adult OP  Duration: 157 minutes
Service Description: ASSESSMENT MH SVC / 3310  Mins Billed to Client: 157 minutes
Provider: JEFFERY, JOANN (041932) - BH Clinician, LMFT
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy:
- Psychoeducation, Unknown Evidence-Based Practice / Service Strategy

Interventions related to objective:
Assessment

Progress Note:

D) I met with Mr. Simpson to open a chart for mental health and medication support services. Mr. Simpson was brought to the appointment by a member of the WIN team. Mr. Simpson was wearing a heavy jacket with multiple layers of clothing underneath and had a strong odor. Mr. Simpson was cooperative. I) I obtained informed consent, reviewed limits of confidentiality, and discussed the purpose of outpatient mental health services. I conducted a clinical interview to gather the necessary information for the completion of a thorough assessment and treatment plan. R) Mr. Simpson was appropriate during the session; however, he escalated somewhat when the discussion turned to his upcoming court date and reason for referral. With support and redirection Mr. Simpson was able to de-escalate quickly. At times Mr. Simpson appeared to be responding to internal stimuli. T) Mr. Simpson is in need of ongoing case management and medication services. He would also benefit from increased socialization. Will work with case management staff for linkage and brokerage, as well as rehab services. Will make a referral for medication services. Explore options for increasing socialization and wellness. Mr. Simpson is agreeable to this plan and signed his treatment plan and was offered a copy, which he declined. Follow up session scheduled for 5/28.

Language Barrier? No
Interpreter Used: No
Interpreters Name: Language: Unknown
Consulted with Primary Care Provider? No
Suicide Risk? None
Homicide Risk? None
Referrals? No Referral Given

Clinician Signature and Discipline

JEFFERY, JOANN (041932) - BH Clinician, LMFT

1/5/2015

Client Progress Note_Sig and Co-Sig DEV
Systems Performance Unit
Version 2.5 - 1/5/2015
Confidential Patient Information
See California Welfare and Institutions Code Section 5328

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SIMPSON, BART
Client Name
75985
Client Number

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Behavioral Health Progress Note
For (75985) SIMPSON BART
Run Date: 1/6/2015

Patient Name: SIMPSON BART, 75985
Admit Date: 1/5/2015
Written By: JEFFERY, JOANN (041932) - BH Clinician, LMFT
Note Type: Does Not Require Co-signature

Program service was provided from: CH MH Adult OP
Service Description: CRISIS INTERVENTION MH SVC / 3710
Provider: JEFFERY, JOANN (041932) - BH Clinician, LMFT
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy: Unknown Evidence-Based Practice / Service Strategy

Date of Service: 1/6/2015
Duration: 74 minutes
Mins Billed to Client: 74 minutes

Interventions related to objective:
Crisis Intervention/de-escalation

Progress Note:
Mr. Simpson arrived at counseling center for unscheduled service. Mr. Simpson was dressed in heavy clothing, appeared dirty, had a strong odor and presented disorganized and confused. Mr. Simpson was rambling about monkey's in space suits and said he could not return home because his home was "booby-trapped" and he was concerned harm would come to him if he returned home. I met with Mr. Simpson to assess for danger to self/others and grave disability. Mr. Simpson stated he had no plans to harm himself, but would do whatever possible to keep himself from being harmed by others, including using violence. Mr. Simpson had no plan for where he would sleep tonight, what he was going to eat, or how he would access medication. Due to his limited support system, I spoke with Mr. Simpson about staying on our stabilization unit if a bed was available. Mr. Simpson states he has not taken his meds for several days and was hesitant to going on the CSU. I contacted CSU staff and they said a bed was available. I spoke with nursing staff at the center and after consulting with the MD they arranged for Mr. Simpson to receive the injection he missed earlier this week. Mr. Simpson accepted the injection and I walked with him to the CSU. I will follow up in the morning to see if Mr. Simpson has stabilized.

Language Barrier? No
Interpreter Used? No
Interpreters Name:
Consulted with Primary Care Provider? No
Suicide Risk? None
Homicide Risk? Ideation
Referrals? Unknown
Referral Comments:
Client admitted to CSU

Clinician Signature and Discipline

JEFFERY, JOANN (041932) - BH Clinician, LMFT

1/6/2015

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# Behavioral Health Progress Note

For (75985) SIMPSON, BART

Run Date: 1/6/2015

<table>
<thead>
<tr>
<th>Service Date: 1/5/2015</th>
<th>Draft/Final Note: Final</th>
<th>Note Category: New Service</th>
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</table>

**Patient Name:** SIMPSON, BART 75985  
**Admit Date:** 1/5/2015  
**Written By:** JEFFERY, JOANN (041932) - BH Clinician, LMFT  
**Note Type:** Does Not Require Co-signature

**Program service was provided from:** CH MH Adult OP  
**Service Description:** REHABILITATION MH SVC / 3450  
**Provider:** JEFFERY, JOANN (041932) - BH Clinician, LMFT  
**Location:** 01 Office / Community MH Center  
**Evidence Based Practice / Service Strategy:** Unknown Evidence-Based Practice / Service Strategy

<table>
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<th>Date of Service:</th>
<th>1/5/2015</th>
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<tbody>
<tr>
<td><strong>Duration:</strong></td>
<td>53 minutes</td>
</tr>
<tr>
<td><strong>Mins Billed to Client:</strong></td>
<td>53 minutes</td>
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</tbody>
</table>

**Note Addresses Which Treatment Plan Problem:**  
Problems: Mr. Simpson stops taking his medication when he is discharged from the hospital.  
Goals: I want to stay in my apartment  
Objectives: Mr. Simpson will decrease incidents of striking others from 2 times per month to 0 times per month.  
Interventions: Group or individual rehabilitation services to teach, model and encourage the use of coping skills.

**Interventions related to objective:**  
Assertive Communication Skills, Social Skills

**Progress Note:**  
D) I met with Mr. Simpson at his house initially for the purpose of a rehab session that was to occur in the community. Mr. Simpson greeted me at the door, which took some time as he had to unlock several locks on his door. Mr. Simpson was dressed appropriately for the weather and appeared clean and recently showered. I) I reminded Mr. Simpson the goal today to utilize public transportation to travel to the community center for a social group. I role played with Mr. Simpson how to ask the bus driver appropriately if he were on the correct bus, as well as how to interact with reception staff once we arrived at the community center. I provided encouragement and support for Mr. Simpson when his anxiety seemed to increase. R) Mr. Simpson walked with me to the bus stop and verbalized being nervous about taking the bus. He was able to successfully get on the bus and paid his fare and appropriately confirmed with bus driver he was on the correct bus. Mr. Simpson appropriately introduced himself to reception staff at the community center and inquired, with some prompting, about social activities that are available. Mr. Simpson verbalized not feeling ready to participate in group today, but did agree to observe. T) Mr. Simpson agreed to take public transportation to the community center at least once between now and our next appt. in 2 weeks. Note includes travel and documentation time.

**Language Barrier:** No  
**Interpreter Used:** No  
**Interpreters Name:**  
**Language:** Unknown  
**Consulted with Primary Care Provider:** No  
**Suicide Risk:** Not Assessed  
**Homicide Risk:** Not Assessed  
**Referrals:** Unknown  

Clinician Signature and Discipline

---

Confidential Patient Information  
See California Welfare and Institutions Code Section 5328

Client Progress Note_Sig and Co-Sig DEV  
Systems Performance Unit  
Version 2.5 - 1/5/2015  

SIMPSON, BART  
Client Name  
75985  
Client Number
Behavioral Health Progress Note
For (75985) SIMPSON,BART
Run Date: 1/5/2015

Service Date: 1/5/2015
Draft/Final Note: Final
Note Category: New Service

Patient Name: SIMPSON,BART, 75985
Admit Date: 1/5/2015
Written By: JEFFERY,JOANN (041932) - BH Clinician, LMFT
Note Type: Does Not Require Co-signature

Episode: 1
Discharge Date:
Written On: 1/5/2015
Note Time: 03:55 PM

Program service was provided from: CH MH Adult OP
Service Description: BROKERAGE MH SVC / 3030
Provider: JEFFERY,JOANN (041932) - BH Clinician, LMFT
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy:
Unknown Evidence-Based Practice / Service Strategy

Date of Service: 1/5/2015
Duration: 58 minutes
Mins Billed to Client: 58 minutes

Note Addresses Which Treatment Plan Problem:
Problems-> Mr. Simpson stops taking his medication when he is discharged from the hospital.
Goals-> I would like to have a friend.
Objectives-> Mr. Simpson will engage in 1 social activity per week; currently Mr. Simpson doesn’t engage in any activities outside of his home.
Interventions-> Targeted case management services to connect Mr. Simpson to peer support resources involving others engaged in maintaining efforts to deal with improved social participation.

Interventions related to objective:
Case Management

Progress Note:
D) I accompanied Mr. Simpson to his first medication appointment with Dr. Kimura. I offered support to client and assisted him in providing necessary information to the doctor. I encouraged Mr. Simpson to openly express his concerns about medication use with the doctor. R) Mr. Simpson was cooperative in talking with the doctor. Initially he seemed to hesitate when asked about his previous experience with medication; however, with support he shared with the doctor some of the negative side effects he experienced. T) Doctor would like to see client for follow-up appointment in two weeks.

Language Barrier? No
Consulted with Primary Care Provider? Yes
Suicide Risk? Not Assessed
Homicide Risk? Not Assessed
Referrals? No Referral Given

Clinician Signature and Discipline

JEFFERY,JOANN (041932) - BH Clinician, LMFT
1/5/2015

Client Progress Note_Sig and Co-Sig DEV Systems Performance Unit
Version 2.5 - 1/5/2015
Confidential Patient Information
See California Welfare and Institutions Code Section 5328

Client Name
SIMPSON,BART
Client Number
75985

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Behavioral Health Medical Progress Note
For (75985) SIMPSON BARTHOLOMEW
Run Date 1/5/2015

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<th>1/5/2015</th>
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<th>SIMPSON.BARTHOLOMEW, 75985</th>
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<tbody>
<tr>
<td>Admit Date:</td>
<td>1/5/2015</td>
</tr>
<tr>
<td>Written By:</td>
<td>Jeffery, Joann</td>
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<tr>
<td>Note Type:</td>
<td>Does Not Require Co-signature</td>
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<td>Date of Service:</td>
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<td>Written On:</td>
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<td>Note Time:</td>
<td>04:30 PM</td>
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Program service was provided from: CH MH Adult OP

Service Description: Medication Support MH Svc F2F / 3630
Provider: JEFFERY, JOANN - Not Required
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy: Medication Management

Date of Service: 1/5/2015
Duration: 41 minutes
Mins Billed to Client: 41 minutes

Client Tx Plan note is written under: Client Treatment Plan

Note Addresses Which Treatment Plan Problem:
- Problems-> Mr. Simpson stops taking his medication when he is discharged from the hospital.
- Goals-> I want to stay out of the hospital.
- Objectives-> Mr. Simpson will have 0 inpatient stays in the next 6 months; Mr. Simpson has had 1 hospitalization in the past month.
- Interventions-> Staff will monitor Mr. Simpson for changes in symptomology or indication of non-compliance and will provide medication support to assist Mr. Simpson in identifying a system to help him remember to take his medication and keep his appointment for injections.

Progress Note:
REASON FOR SERVICE: In for Zyprexa injection. Facilitated medication appointment with Dr. Gray. GENERAL APPEARANCE: Casually dressed, slightly disheveled, but improved from last visit. PSYCHOMOTOR BEHAVIOR: Restless, agitated. MEDICAL: Denies acute medical problems. MOOD/AFFECT: Labile/flat. SPEECH: Pressured, Clear with some mumbling. COGNITION: Denies impairment. THOUGHT PATTERNS / CONTENT: Presents thoughts in a somewhat disorganized manner. Denies psychosis but reports hearing the voices of his TV daily. States his apartment is wired and that his neighbors are spies. Refused to answer some questions stating, "I'm not going to answer the same question twice." Clt. reports not getting along with his elderly neighbor, but also stated he will not hit her again. APPETITE: Client reports he has been eating more. ADL'S: "I shower when I have to go out", clothes appeared clean and client was clean. CURRENT MEDICATIONS: Zyprexa injection given. Client reports he has been taking the trazodone, but is still worried about taking the multi-vitamin. Tolerated inj. procedure without complaint. SIDE EFFECTS FROM MEDICATIONS: Client reports no side effects, but asked if I injected him with another tracking sensor because his last injection hurt. COMPLIANCE WITH MEDICATION USE: Keeping appts q.2 wks. with assist from SEARCH staff. SLEEP PATTERNS: Reports 8 hrs. sleep last night and most nights. SUBSTANCE USE: Denies drugs/ETOH. Smokes tobacco. CLIENT CONCERNS: Client worried about whether he will have to go to court if charges are going to be dropped for hitting his neighbor. CLIENT PROGRESS TOWARDS OBJECTIVES: Client is participating in treatment and has shown some improvement. PLAN: New orders escribed to pharmacy. Med checks and inj. q. wks. Supported med understanding and adherence.

Is this an initial evaluation? No
Is this an Ampl Telehealth Appt? No

MSE

Physical Appearance: Underweight

Medical Progress Note by Client
Version 1.3
12/15/2014
Confidential Patient Information
See California Welfare and Institutions Code Section 5328

SIMPSON, BARTHOLOMEW
Client Name
75985
Client Number
Behavioral Health Progress Note
For 75985 SIMPSON BART
Run Date: 1/6/2015

Service Date: 1/5/2015
Draft/Final Note: Final
Note Category: New Service

Patient Name: SIMPSON BART, 75985
Admit Date: 1/5/2015
Written By: JEFFERY, JOANN (041932) - BH Clinician, LMFT
Note Type: Does Not Require Co-signature
Episode: 1
Discharge Date: Written On: 1/5/2015
Note Time: 04:26 PM

Program service was provided from: CH MH Adult OP
Service Description: BROKERAGE MH SVC / 3030
Provider: JEFFERY, JOANN (041932) - BH Clinician, LMFT
Location: 03 Phone
Evidence Based Practice / Service Strategy:
Unknown Evidence-Based Practice / Service Strategy

Date of Service: 1/5/2015
Duration: 15 minutes
Mins Billed to Client: 15 minutes

Note Addresses Which Treatment Plan Problem:
Problems -> Mr. Simpson stops taking his medication when he is discharged from the hospital.
Goals -> I want to stay out of the hospital.
Objectives -> Mr. Simpson will have 0 inpatient stays in the next 6 months; Mr. Simpson has had 1 hospitalization in the past month.
Interventions -> Staff will monitor Mr. Simpson for changes in symptomology or indication of non-compliance and will provide medication support to assist Mr. Simpson in identifying a system to help him remember to take his medication and keep his appointment for injections.

Interventions related to objective:
Other

Other Intervention:
Client Support

Progress Note:

D) Unscheduled phone call from Mr. Simpson who states he doesn’t want to come in for his injection appt. later this week because he is concerned staff aren’t really giving him medication, but instead injecting him with more tracking devices. I) I praised Mr. Simpson for calling and offered support. I explored with client if he would be willing to come in and talk with the doctor about his concerns. After some discussion I agreed to follow up with MD and relay Mr. Simpson’s concerns. R) Client initially agitated when he called and emphatic he would no longer take the injections. Mr. Simpson able to recognize meds may be helping him and said he was afraid to talk with the doctor. Mr. Simpson asked that I talked with the doctor and if the MD and I agreed it was best for Mr. Simpson to take the medication then he would. T) I will follow up with MD to relay Mr. Simpson’s concerns about the injection. Documentation completed during call.

Language Barrier? No
Interpreter Used: No
Interpreters Name: 
Language: Unknown
Consulted with Primary Care Provider? No
Suicide Risk? Not Assessed
Homicide Risk? Not Assessed
Referrals? No Referral Given

SIMPSON BART
Client Name
75985
Client Number
<table>
<thead>
<tr>
<th>Clinician Signature and Discipline</th>
<th>1/5/2015</th>
<th>Date</th>
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<tbody>
<tr>
<td>JEFFERY, JOANN (041932) - BH</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>Clinician, LMFT</td>
<td></td>
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<table>
<thead>
<tr>
<th>Client Progress Note, Sig and Co-Sig DEV</th>
<th>Page 6 of 11</th>
<th>SIMPSON, BART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems Performance Unit</td>
<td></td>
<td>Client Name</td>
</tr>
<tr>
<td>Version 2.5 - 1/5/2015</td>
<td></td>
<td>75985</td>
</tr>
</tbody>
</table>

Confidential Patient Information
See California Welfare and Institutions Code Section 5328

Client Number

71
Behavioral Health Progress Note
For (75985) SIMPSON BART
Run Date: 1/6/2015

Service Date: 1/5/2015  Draft/Final Note: Final  Note Category: New Service

Patient Name: SIMPSON BART, 75985  Episode: 1
Admit Date: 1/5/2015  Discharge Date: Written On: 1/5/2015
Written By: JEFFERY, JOANN (041932) - BH Clinician, LMFT  Note Time: 04:33 PM
Note Type: Does Not Require Co-signature

Program service was provided from: CH MH Adult OP
Service Description: PLAN DEVELOPMENT MH SVC / 3810
Provider: JEFFERY, JOANN (041932) - BH Clinician, LMFT
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy:
Unknown Evidence-Based Practice / Service Strategy

Date of Service: 1/5/2015  Duration: 18 minutes
Mins Billed to Client: 18 minutes

Note Addresses Which Treatment Plan Problem:
Problems-> Mr. Simpson stops taking his medication when he is discharged from the hospital.
Goals-> I want to stay out of the hospital.
Objectives-> Mr. Simpson will have 0 inpatient stays in the next 6 months; Mr. Simpson has had 1 hospitalization in the past month.
Interventions-> Staff will monitor Mr. Simpson for changes in symptomology or indication of non-compliance and will provide medication support to assist Mr. Simpson in identifying a system to help him remember to take his medication and keep his appointment for injections.

Interventions related to objective:
Plan Development

Progress Note:
D) After speaking with Mr. Simpson, I followed up with Dr. Gray to convey Mr. Simpson’s concerns. I) I spoke with Dr. Gray and explained Mr. Simpson’s concern that we are injecting him with tracking devices and asked for input. R) Dr. Gray was responsive and indicated there are other medication options and he is happy to discuss them with the client. Dr. Gray explained that the injections were good because Mr. Simpson seems to be more compliant with the injections than his oral medications. T) I will follow-up with Mr. Simpson and let him know that we are here to help him and not to cause harm and that I will attend his next injection and medication appointment for support if he wants me to be present. I will also let him know that Dr. Gray will talk with him about his concerns and other medication options if needed. Note written concurrently.

Language Barrier? No  Interpreter Used: No  Interpreters Name: Language: Unknown
Consulted with Primary Care Provider? No  Suicide Risk? Not Assessed
Homicide Risk? Not Assessed  Referrals? Unknown

Clinician Signature and Discipline

Client Progress Note_Sig and Co-Sig DEV Systems Performance Unit
Version 2.5 - 1/5/2015
Confidential Patient Information
See California Welfare and Institutions Code Section 5328

SIMPSON, BART
Client Name
75985
Client Number

Page 7 of 11
Behavioral Health Progress Note
For (75865) SIMPSON.BART
Run Date: 1/6/2015

Service Date: 1/5/2015
Draft/Final Note: Final
Note Category: New Service

Patient Name: SIMPSON.BART 75865
Admit Date: 1/5/2015
Written By: JEFFERY.JOANN (041932) - BH Clinician, LMFT
Note Type: Does Not Require Co-signature
Episode: 1
Discharge Date: 
Written On: 1/5/2015
Note Time: 04:45 PM

Program service was provided from: CH MH Adult OP
Service Description: REHABILITATION MH SVC GROUP / 3570
Provider: JEFFERY.JOANN (041932) - BH Clinician, LMFT
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy:
Unknown Evidence-Based Practice / Service Strategy
Date of Service: 1/5/2015
Duration: 67 minutes
Mins Billed to Client: 17 minutes
# in Group: 

Note Addresses Which Treatment Plan Problem:
Problems-> Mr. Simpson stops taking his medication when he is discharged from the hospital.
Goals-> I want to stay in my apartment
Objectives-> Mr. Simpson will decrease incidents of striking others from 2 times per month to 0 times per month.
Interventions-> Group or individual rehabilitation services to teach, model and encourage the use of coping skills.

Interventions related to objective:
Communication skill-building, Social Skills

Progress Note:
D) Mr. Simpson arrived on time for scheduled social activity group. He was dressed semi-appropriately; however, he had on a heavy coat despite the almost 100 degree weather outside. The purpose of the group was to encourage appropriate social skills and provide clients the opportunity to practice these skills with one another. 1) I provided art/cart supplies and asked group members to find a partner to work with. I provided instruction to utilize materials to make something creative. I monitored activity and modeled appropriate methods to ask appropriately for needed items, provided redirection as needed, and encouraged cooperation. R) Initially Mr. Simpson hesitant to engage with another group member and verbalized his preference to work alone, with encouragement and reminder that social activities support healthy relationships, Mr. Simpson was able to participate in the activity. Mr. Simpson required some redirection and modeling to appropriately communicate his needs; however, he took the cues and was able to appropriately request needed items. Mr. Simpson smiled several times throughout the group and proudly shared the birdhouse he built with other group member. T) Mr. Simpson agreed to return for group next week. Will continue with current plan.

Language Barrier? No
Interpreter Used? No
Interpreters Name:
Language: Unknown

Consulted with Primary Care Provider? No
Suicide Risk? Not Assessed
Homicide Risk? Not Assessed
Referrals? Unknown

Clinician Signature and Discipline

Client Progress Note_Signature and Co-Signature DEV
Systems Performance Unit
Version 2.5 - 1/5/2015
Confidential Patient Information
See California Welfare and Institutions Code Section 5328

Client Name
75865
Client Number
# ADULT DISCHARGE DIAGNOSIS

Behavioral Health Client Diagnosis Report
for (75985) SIMPSON, BART  Program: (44023) OR MH Adult OP
Run Date: 1/6/2015
Diagnosing Clinical Staff: (041932) JEFFERY, JOANN
Diagnosis Type: Discharge - Final
AOD Diagnosis?: No

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<th>1/6/15 01:51 PM</th>
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<td>Axis I - Primary</td>
<td>295.32 “SCHIZOPHRENIC DISORDER, PARANOID TYPE, CHRONIC”</td>
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<tr>
<td>Axis I - Secondary</td>
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<td>Axis I - Tertiary</td>
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<td>Axis I - (4)</td>
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<tr>
<td>Axis I - Provisional</td>
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<tr>
<td>Axis II (1)</td>
<td>V71.09 NO DIAGNOSIS OR CONDITION ON AXIS I OR II</td>
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<td>Axis III (1)</td>
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<td>Axis III - Other</td>
<td>Chronic cough &amp; poor nutrition</td>
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<td>Axis IV Primary Support Group:</td>
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<td>Social Environment:</td>
<td>Yes</td>
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<td>Education:</td>
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<td>Axis V</td>
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<tr>
<td>12 Mo High</td>
<td>(35) 31 - 40 Impairment In Reality Test</td>
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<tr>
<td>12 Mo Low</td>
<td>(29) 21 - 30 Delusions Or Hallucinations</td>
</tr>
</tbody>
</table>

**Personality Features #1:**
**Personality Features #2:**

### Clerical Data Entry of CSI Data:

**CSI Information:**
- Trauma: Unknown
- Substance Abuse / Dependence: No

**General Medical Condition Summary Code:**
- Other

---

JEFFERY, JOANN (041932) - BH Clinician, LMFT

1/6/2015

This diagnosis was originally completed by: 041932, JEFFERY, JOANN

---

Client Diagnosis Report
Version 1.3 12/16/2014

Confidential Patient Information
See California Welfare and Institutions Code Section 5328

Page 1 of 2

SIMPSON, BART
Client Name: 75085
Client Number
Behavioral Health Client Diagnosis Report
for (75985) SIMPSON BART  Program: (44023) OR MH Adult OP
Run Date: 1/6/2015
Diagnosing Clinical Staff: (041932) JEFFERY JOANN
Diagnosis Type: Discharge - Final

I pulled forward the BCDBH Diagnosis and did not make any changes  N/A
BCDBH Discharge Information Report

Data Run Date: 1/8/2015

Discharge Data For: (75985)SIMPSON,BART

Program: (44023) OR MH Adult OP
Discharge Practitioner: JEFFERY JOANN
Date of Discharge: 1/8/2015
Discharge Day of Week: TUESDAY
Time of Discharge: 03:01 PM
Length of Stay: 1
Type of Discharge: Transfer To Another DBH Facility
Discharge remarks/Comments: Client was transferred to another reporting unit.

Demographics:

Address:
Chico CA
95928 No Entry

Communication Preference: No Entry

Primary Language: English Race: White
Ethnic Origin: Unknown Religion: No Entry
Place of Birth: Country of Origin: No Entry
Maiden Name: Marital Status: No Entry
Education: 13 Years Employment Status: Not In Labor Force - Unable To Work Due
Occupation: No Entry Smoker: No Entry

CSI:

Patient Status Code: Still a patient or expected to return
Discharge Legal Status: Voluntary- W8000

Page 1 of 2

BCDBH Discharge RPT
Version 1.1 12/15/2014
Confidential Patient Information
See California Welfare and Institutions Code Section 5328
Discharge Data For: (75985) SIMPSON, BART

Episode: 2

Referred/Transfer:

Referred To: Other DBH Program

Transferred To: CSU

During this Episode the client: Not Applicable

Client Living Arrangement at Discharge: Board And Care

JEFFERY, JOANN, Not Required 1/6/2015

Date

Page 2 of 2

SIMPSON, BART

Client Name

75985

Client Number

BCDBH Discharge RPT
Version 1.1 12/15/2014

Confidential Patient Information
See California Welfare and Institutions Code Section 5328
BCDBH - Informed Consent for Services
For (75666) TEST, BILLY
Episode # 1
Final

Services:
I understand that all services are voluntary. I have the right to be informed about services to participate in their selection, and to withdraw this consent at any time, except to the extent that action has already been taken. Services include assessment, and may also include individual, group, family, and multifamily counseling; case management; medications; crisis intervention; recreational and vocational therapy; parent education; and independent living skills. Acceptance and participation in these services shall not be considered a prerequisite for access to other community services. I have the right to request a change of provider, staff person, therapist, and/or case manager.

Confidentiality:
I understand that my relationship with Butte County Department of Behavioral Health is confidential unless I give written permission to release information to a specific source, except in certain life and death emergencies or by court order. I also understand that if a staff person seriously believes that I intend to harm others, or myself, or suspects child or elder abuse/neglect, s/he is legally and ethically bound to report this information to the appropriate authorities.

Contract for Services:
I understand that I am responsible for cooperating with my clinician/case manager, and for keeping my appointments or calling to cancel them in a timely manner. I understand that if I am more than ten minutes late for a group, I may not be admitted into the group. I also understand that if I fail to follow through with my treatment, my case may be closed.

I Have Read and Understand the Above Statements and Give my Consent for Treatment.
Unless I withdraw my consent earlier, this consent will expire one year from the date of my signature. I have the right to receive a copy of this document. I reserve all rights provided to me by law not waived by the scope of this consent and authorization.

| Copy of informed consent offered? | Yes |
| Member information offered?      | Yes |
| Advanced Directive Info Sheet offered (Adults only)? | N/A |

Required Signature(s):

Client Signature

Date: 1/8/2015

Parent/Guardian Signature

Date: 1/8/2015

JEFFERY, JOANN (041932) - BH Clinician, LMFT

Date: 1/8/2015

This consent was originally obtained by:
(041932) JEFFERY, JOANN

Date of Consent: 1/8/2015

BCDBH Informed Consent
Ver 1.3 12/5/2014

Confidential Patient Information
See California Welfare and Institutions Code Section 5328

TEST, BILLY
Client Name
75666
Client Number
Acknowledgement of the Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practices from the Butte County Department of Behavioral Health.

Signed: ____________________________ on this date: 1/6/2015

Parent/Guardian Signature

Required Signature(s):

______________________________ 1/6/2015
JEFFERY, JOANN (041932) - BH
Clinician, LMFT

75986
Client Number
TEST, BILLY

Client Name
Acknowledgement of Receipt of the Guide to Medi-Cal Mental Health Services

For (75988) TEST,BILLY Program: 40171 CH MH Youth OP
Episode Number: 1
Date: 1/5/2015 Draft/Final: Final

Client DID receive a copy of the guide to Medi-Cal Mental Health Services.   Yes

Required Signature(s):

JEFFERY,JOANN (041032) - BH Clinician, LMFT

1/5/2015 Date

TEST,BILLY

Client Name

75988

Client Number

Acknowledgement of MMHS

Confidential Patient Information
See California Welfare and Institutions Code Section 5328

Ver 1.2 12/8/2014
# Behavioral Health Mental Status Exam

**For (125088) TEST BILLY**  
**Program: (40171) CH MH Youth OP**  
**Assessing Clinician: (041832) JEFFERY JOANN**  
**Mental Status Exam Type: Final**

## General Appearance
- **Dress:** Appropriate  
- **Facial Expressions:** Sad, Worried, Avoids Gaze  
- **Grooming:** Clean, Neat  
- **Body Size:** Average, Thin

## Psychomotor Behavior
- **Gait:** Slow, Hesitant  
- **Abnormal Movements:** None  
- **Posture:** Slouched  
- **Rate of Movement:** Slowed  
- **Coordination of Mvmt:** WNL

## Mood / Affect
- **Range of Affect:** Blunted, Constricted  
- **Interview Behavior:** Withdrawn, Passive  
- **Mood:** Depressed, Anxious

## Speech
- **Rate of Speech:** Slow, Hesitant  
- **Intensity of Volume:** Soft  
- **Clarity:** Clear  
- **Quality:** Monotonous  
- **Quantity:** Responds only to questions

## Cognition
- **Attn/Concentration:** Satisfactory  
- **Memory:** WNL  
- **Abstraction:** Appropriate  
- **Insight:** Slight Awareness  
- **Orientation:** Person, Place, Time, Situation  
- **Judgment:** Fair  
- **Intellect:** Average

## Thought Patterns
- **Clarity of Thought:** Coherent  
- **Relevance:** Logical, Relevant  
- **Flow of Thought:** WNL  
- **Content of Thought:** Somatic Complaints, Hopelessness
Mental Status Exam For: (75986) TEST, BILLY
Assessing Clinician: (041932) JEFFERY, JOANN

Mental Status Exam Type: Final  MSE Date: 1/6/2015  Episode #1

Hallucinations: None
Illusions: Not Present
Delusions: None
Suicide: Ideation, Recent, Method Unavailable, Risk Low
Homicide: None

Level of Consciousness
Lvl of Consciousness: Lethargic

Required Signature:

JEFFERY, JOANN (041932) - BH Clinician, LMFT

01/08/2015  Date

Licensed Clinician Signature Date

This MSE was originally completed by: 041932 JEFFERY, JOANN

I pulled forward the BH Mental Status Exam and did not make any changes N/A
Behavioral Health Clinical Assessment of (75986) TEST BILLY

Assessment Date: 1/8/2015

Assessing Clinician: (041922) JEFFERY JOANN

Assessment Type: Initial

Next Assessment Due: 1/6/2016

Assessment Type: Final

Youth or Adult: Youth

Clinical Assessment of (75986) TEST BILLY

Assessment Date: 1/8/2015

Assessment Type: Initial

Program: (49171) CHIM Youth OP

Client Demographic Data:

Age as of Assessment: 7.67 years

Gender: Male

Education: 2 Years

Living Arrangements: Foster family home

Marital Status: Single

Employment: Not in Labor Force - Student

Ethnicity/Race: White

Primary Language: English

Smoker: Never Smoked

Presenting Problems Past and Present

General Appearance:
Billy is dressed appropriately and neatly groomed. He appears his stated age in size and stature. He has downcast eyes and was somewhat "hiding" behind mom, but when offered toys to play with, he hesitantly accepted them and played quietly.

Presenting Problems, History, Duration of Presenting Symptoms, Precipitating Events and Stressors:
Mom reports Billy has had ongoing unhappiness for several years, no interaction with peers, frequent somatic complaints (most intense when preparing for school in the mornings and have escalated in the last 3 months), difficulty completing schoolwork, worries, hopes, and has recently (past 3 months) become clingy and demanding with parents worrying something bad is going to happen to them. In the past two weeks Billy has demanded his brother sleep with him because he is afraid to go to sleep at night. Sadness has increased over the past 6 months as he has had low energy, decreased appetite, no interest or enjoyment in play, and difficulty falling and staying asleep. 3 weeks ago Billy verbalized wanting to die and that he may shoot himself and his mother is worried that he is significantly depressed. Billy's symptoms have resulted in poor school performance and attendance, poor sleep, no social interaction, and difficulty with family relationships.

Client History and Information: At Birth

Prenatal Drug Exposure:
No

Child Was Born:

On Time

Fetal Distress:

No

Failed To Cry:

No

Appeared Inactive:

No

Difficulty Breathing:

No

Physical/Medical Problems at Birth:

No

Abnormal Weight at Birth:

No

Client History and Information: Developmental History

Client Name: TEST BILLY

Client Number: 75986

Page 1 of 4

BCDBH Initial Assessment Rpt

Version 1.3 DEV 12/1/2014

Confidential Patient Information

See California Welfare and Institutions Code Section 5323
Clinical Assessment of (75986) TEST BILLY

Assessment Date: 1/9/2015
Assessment Type: Final

Assessing Clinician: (041932) JEFFERY JOANN
Program: (49171) CH MH Youth OP

Episode #: 1

Crawled:
Average (6-9 months)

Walked Alone:
Average (9-18 months)

Followed Simple Commands:
Average (12 to 18 months)

Used Simple-Word Sentences:
Average (2-24 months)

Other Developmental Problems:

Mother reports a normal pregnancy and delivery with no complications. Billy was fussy as a baby, but met developmental milestones. M

Client History and Information

Educational History:

Billy did well in 1st grade, but due to attendance problems caused by somatic symptoms, as well as difficulty concentrating due to worry Billy is falling behind academically. He is in a 2nd grade classroom, but is not completing his schoolwork. Billy sometimes feels he needs to do his papers until they are perfect.

Employment History:

Billy has never been employed due to his age.

Client’s Cultural/Spiritual Belief and Family Background:

Billy is African American and lives in a culturally diverse neighborhood. The parents have both been actively involved in various community activities. Both of Billy’s parents grew up in this area. Mother reports the family has Christian beliefs and that they attend a nearby non-denominational church. Both sets of grandparents live nearby and while they are loving, they are concerned about Billy’s behavior and aren’t quite sure how to help. Nobody in either side of Billy’s family has ever reached out for help with a mental disorder. Mother said she and Billy’s father are in agreement that they need help in assisting Billy in feeling better. They are not opposed to medication, but would like to avoid it if possible. Both parents are college educated; however, due to the current economy the family’s income has decreased. Additionally, shortly after Billy began 2nd grade, mom lost her job due to cutbacks.

Father has recently picked up an extra shift at work to try and cover expenses.
Clinical Assessment of (75996) TEST.BILLY
Assessing Clinician: (041932) JEFFERY JOANN
Assessment Date: 1/9/2015
Assessment Type: Final
Program: (49171) CH MH Youth OP

Social and Relationship History (include current or past legal issues and sexuality):
Billy has never socialized with his peers. When asked if he has any friends at school, Billy quietly replied, “no”. Mom reports she and Billy's father have tried to get Billy involved in various activities, but he doesn't want to play sports, take music lessons, or interact with other kids. Billy spends his time outside of school lying on the couch watching television.

Does Substance Use Interfere/Exacerbate MH Problems:
No

Mental Health Treatment History (include psychiatric hospitalizations and family psychiatric history):
Mother reports some depression and anxiety in her family, but none that has ever risen to the level of needing outside help. This is Billy's first time coming in for mental health services.

Medical Issues:
Yes

Please explain Medical Issues:
Billy complains of frequent headaches and stomachaches; however he recently had a full physical that included a full neurological examination and an EEG, the results of which were normal. His bloodwork came back normal as well. After this thorough physical, Billy's PMD suggested mom follow-up with mental health.

Life Threatening Allergies:
No

Prescribed Medications: (for psychiatric and medical conditions, include OTC medications)
Billy sometimes takes Claritin for allergies. Mom has recently begun giving Billy Benadryl at night at the direction of his pediatrician to see if this would help with his sleep. Mom reports the Benadryl hasn't made a difference. Billy has never had caffeine, tobacco, alcohol or other drugs.

Medication Allergies/Adverse Reactions:
None noted or reported.

Clinical Formulation

Date of Medical Necessity Determination:
Jan 06 2015 -Jeffery, Joann

Date of Mental Health Exam:
Jan 06 2015 12:00AM-Jeffery, Joann

Service Needs/Recommendations:
Billy will likely benefit from weekly individual play therapy, sand tray therapy and/or art therapy. Billy's parents will benefit from opportunities to learn and understand Billy's mental health diagnosis and how they can help him. Linkage and Brokerage with the school may be beneficial as well to assist Billy in the classroom. If no improvement with therapy, collateral services to the parents and brokerage with the school, Billy may need a referral for a psychiatric examination to determine if medication is appropriate.

Presenting Problems #1:
Billy's somatic complaints and worry are hindering his ability to attend school

Client Strengths in Addressing Problem:
Billy states that he likes school.
Clinical Assessment of (73988) TEST BILLY
Assessment Date: 1/8/2015
Assessment Type: Final
Assessing Clinician: JEFFEY, JOANN
Episode #: 1
Program: (4071) GH MH Youth OP

Presenting Problems #2:
Billy’s symptoms are preventing him from developing appropriate peer relationships.

Client Strengths in Addressing Problem:
Billy’s parents are supportive and Billy stated he would like to have more fun and have some friends.

Required Signature(s):

______________________________________________
JEFFEY, JOANN (041932) - BH
Clinician, LMFT
Date: 1/8/2015
Assessing Clinician

Initial Assessment Originally Completed by: JEFFEY, JOANN

I pulled forward the BCDBH Initial Assessment and did not make any changes: N/A
Behavioral Health Client Diagnosis Report
for (75986) TEST BILLY  Program: (40171) CH MH Youth OP
Run Date: 1/6/2015
Diagnosing Clinical Staff: (041932) JEFFERY,JOANN
Diagnosis Type: Admission - Final
AOD Diagnosis: No

Diagnosis Date and Time: 1/6/15 03:57 PM  
Episode: 1

Primary Diagnosis: 309.21 SEPARATION ANXIETY DISORDER
Axis I - Primary 309.21 SEPARATION ANXIETY DISORDER
Axis I - Secondary 296.23 MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, SEVERE, W/O MENTION OF PSYCHOTIC BEHAVIOR
Axis I - Tertiary
Axis I - Provisional
Axis II(1) V71.09 NO DIAGNOSIS OR CONDITION ON AXIS I OR II
Axis II(2)
Axis II - Provisional
Axis III(1)
Axis III(2)
Axis III - Other
Axis IV Primary Support Group: Yes
Social Environment: Yes
Education: Yes
Occupation: No
Housing: No
Economic: No
Health Care: No
Legal: No
Other: Yes

Axis V (45) 41-50 Serious Symptoms Or Impair
12 Mo High (65) 61-70 Mild Symptoms Or Some Difficulties
12 Mo Low (45) 41-50 Serious Symptoms Or Impairment

Personality Features #1:
Personality Features #2:

Clerical Data Entry of CSI Data:

CSI Information:
Trauma: No  Substance Abuse / Dependence: No

General Medical Condition Summary Code:
Unknown / Not Reported General Medical Condition

This diagnosis was originally completed by: 041932, JEFFERY,JOANN
Behavioral Health Client Diagnosis Report
for (75886) TEST BILLY  Program: (40171) CH MH Youth OP
Run Date: 1/8/2015
Diagnosing Clinical Staff: (041832) JEFFERY JOANN
Diagnosis Type: Admission - Final
AOD Diagnosis?: No

I pulled forward the BCDBH Diagnosis and did not make any changes. N/A
**Behavioral Health Medical Necessity Determination**  
for (75686) TEST.BILLY  
Episode# 3  
Admit Date: 1/8/2015  
(40171) CH MH Youth OP

**MND Date:** 1/8/2015  
**Evaluator:** 041932  
**Report Date:** 1/8/2015  
**MND Type:** Initial  
**Draft/Final:** Final

---

**Presenting Problem:**
Mother accompanied 7 year old Billy to screening assessment and reports, “Billy is unhappy and always complaining about feeling sick.” Mother reports Billy has never really been happy and doesn’t play with other children. Since pre-school, Billy has complained about stomachaches, headaches, and various other physical problems. These complaints are most intense in the morning when Billy is getting ready for school and have escalated in the last few months. Billy had a complete medical examination, including a neurological examination and electroencephalogram, results of which were normal. Billy is having difficulty completing his schoolwork in second grade but he did well in first grade. Due to the somatic complaints it is difficult to get Billy to school, but if he is allowed to stay home he worries about getting behind in his assignments. Billy feels hopeless about his situation at school as he is often unable to complete his work even when he attends school. Billy had his mom write him a note that he carries with him when he does attend school to get through the day. The note says: “You are not getting out of school early today. If you feel that you have to do your papers over and over again, please just do the best you can. Do not think about the time of day and it will go quickly.” Lately, Billy has begun to worry outside of school and is clingy and demanding of his parents. He worries that something bad has happened to his parents if they come home late or leave without him. For the past two weeks he has insisted his little brother sleep with him because he is afraid to go to bed at night alone. Billy’s mother is concerned that his unhappiness has increased over the past 6 months and that he is significantly depressed. He has low energy, no interest or enjoyment in playing and has a decreased appetite. He has trouble falling asleep at night and often wakes up in the middle of the night or very early in the morning. Three weeks ago Billy talked about wanting to die and indicated that he may shoot himself. This was the first time Billy has verbalized SI.

---

**Impairment Area**

**Living Arrangement/Housing:**
Currently not an issue

**Activities of Daily Living:**

**Significant Impairment**

**Explain:** Billy has no interest in engaging in developmentally appropriate activities.

**Primary Support Group:**

**Significant Impairment**

**Explain:** Billy has unrealistic worries about possible harm to his parents and has been clingy and demanding with them.

**Education:**

**Significant Impairment**

**Explain:** Due to school refusal and a tendency toward perfection Billy has fallen behind in his academics.

**Financial Economic Issues:**
Currently not an issue

**Access to Health Care Services:**
Currently not an issue

**Social Relationship/Environment/Community:**

**Significant Impairment**

**Explain:** Billy has no peer relationships and does not socialize with others.

---

**BCDBH Medical Necessity Determination**  
Version 1.8  
DEV 12/2/2014  
Confidential Patient Information  
See California Welfare and Institutions Code Section 5328
Medical Necessity Determination Continued

School Situation:
- Significant Impairment
  
  Explain: Billy often refuses to attend school due to somatic complaints.

Service Indicators

Substance Use:
- None Known

Victim related trauma:
- None

Briefly explain victim related trauma:

Suicidal/Self Harm - Current
- Ideation
  - What is the safety plan? Three weeks ago Billy indicated he wanted to die and discussed shooting himself. Mother states there are no guns in the home and Billy does not have access to guns at school.

Suicidal/Self Harm - Past:
- None

Homicidal/Danger to Others - Current:
- None

Homicidal/Danger to Others - Past:
- None

Medical Necessity

Primary DSM-IV Diagnosis that will be the focus of the intervention provided:

Provisional Diagnosis: Mood disorders/severe

Client must have at least one of the following impairments:
- A probability of significant deterioration in an important area of life functioning.
- A significant impairment in an important area of life functioning.
- Child will not progress developmentally as individually appropriate.
- Not Applicable.

Client must have at least four of the intervention criteria:
- Child won't develop as individually appropriate.
- Client will benefit from intervention.
- Condition will not respond to primary health care alone.
- Intervention focuses on functional impairment.
- Prevent deterioration in life function.
- Significantly diminish the functional impairment.
- Treatment intervention not applicable.

Client’s condition is expected to be responsive to Specialty Mental Health Services? Yes
<table>
<thead>
<tr>
<th>Disposition</th>
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<tbody>
<tr>
<td><strong>Scheduled Assessment:</strong> Yes</td>
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<tr>
<td><strong>Staff scheduled for intake assessment:</strong> <strong>041192</strong></td>
</tr>
<tr>
<td><strong>Do you have a Primary Physician?</strong> Yes</td>
</tr>
<tr>
<td><strong>Name of Primary Care Physician:</strong> Dr. Feel Good</td>
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<tr>
<td><strong>Where did you refer client for Primary Care Services?</strong></td>
</tr>
<tr>
<td><strong>Referrals Made:</strong></td>
</tr>
</tbody>
</table>
Medical Necessity Determination Continued

Substance Use History

Caffeine: None
Alcohol: None
Tobacco: None
Cannabis: None

OTC/Complimentary/Alternative Medication: None
Prescription: None
Illicit Drugs: None

Other: None

Substance-related diagnosis indicated? No

Comments (support diagnosis if applicable):

Initial Assessment Originally Completed by: JEFFERY, JOANN

I pulled forward the Medical Necessity Determination and did not make any changes.
Behavioral Health Client Treatment Plan
for (75986) TEST,BILLY Episode # 1
Program: (40171) CH MH Youth OP

Plan Date: 1/7/15   Plan Type: Initial   Draft/Final: Unknown   Last date updated: 1/7/15
Plan End Date:   Plan Name: CH MH YOUTH W&R   Last updated by: Washington, George

PROBLEM: Billy’s symptoms are preventing him from developing appropriate peer relationships.

Assigning Staff: WASHINGTON,GEORGE   Status: Treat
Responsible Staff: WASHINGTON,GEORGE

Goal: Billy would like to have friends.
Strengths: Billy is kind and caring
Obstacles: Billy has no interest in activities, has low energy, and worries when he is separated from his parents.

Objective: Billy will make and maintain at least one new friendship in the next year. Currently Billy has no peer relationships.

<table>
<thead>
<tr>
<th>Duration: 12 Months</th>
<th>Is this an Integrated Intervention?</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency: Weekly</td>
<td>Intervention: Therapist will utilize play therapy to model and teach appropriate social skills</td>
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<th>Is this an Integrated Intervention?</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency: Monthly</td>
<td>Intervention: Provide brokerage and linkage to assist client and family in identifying and connecting with age appropriate social activities</td>
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</tbody>
</table>

PROBLEM: Billy’s symptoms are preventing him from developing appropriate peer relationships.

Assigning Staff: Unknown   Status: Treat
Responsible Staff: Unknown

Goal: Billy would like to have friends.
Strengths: Billy is kind and caring
Obstacles: Billy has no interest in activities, has low energy, and worries when he is separated from his parents.

Objective: Billy will make and maintain at least one new friendship in the next year. Currently Billy has no peer relationships.

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</thead>
<tbody>
<tr>
<td>Frequency: Monthly</td>
<td>Intervention: Provide brokerage and linkage to assist client and family in identifying and connecting with age appropriate social activities</td>
<td></td>
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</tbody>
</table>
Plan Date: 1/7/15        Plan Type: Initial        Draft/Final: Final
Plan End Date: 1/6/16        Plan Name: CH MH YOUTH W&R        Last date updated: 1/7/15
Last updated by: Washington, George

Duration: 12 Months
Frequency: bi-monthly
Intervention: Family therapy to improve communication, coach communication skills, boundary setting, rule setting, and appropriate expectations.

Duration: 12 Months
Frequency: bi-monthly
Intervention: Collateral services to provide psycho-education regarding client's depressive symptoms, and develop skills with caregivers to support client's goals.

Duration: 12 Months
Frequency: Weekly
Intervention: Rehabilitation services to teach skill building, practice social skills, and coping skills to manage depressive symptoms.

Duration: 12 Months
Frequency: Quarterly
Intervention: Intensive Home Based Services (IHBS) to assist parents and client in developing healthy coping strategies to address depression.

Duration: 12 Months
Frequency: bi-monthly
Intervention: Intensive care coordination to collaborate with client's other service providers, school, family members and support system.

**PROBLEM:** Billy's symptoms are preventing him from developing appropriate peer relationships.

Assigning Staff: WASHINGTON, GEORGE
Responsible Staff: WASHINGTON, GEORGE
Status: Treat

**PROBLEM:** Billy's somatic complaints and worry are hindering his ability to attend school

Assigning Staff: WASHINGTON, GEORGE
Responsible Staff: WASHINGTON, GEORGE
Status: Treat

**Goal:** Billy would like to remain at school for the entire day daily.

**Strengths:** Billy states that he likes school and he did well in first grade.

**Obstacles:** Billy worries about many things and has frequent somatic complaints which interfere with his ability to attend and stay at school.

**Objective:** Billy will improve school attendance from currently 3 days per week to 5 days per week.

Duration: 12 Months
Frequency: bi-monthly
Intervention: Individual and family therapy to provide psycho-education regarding connection of somatic complaints with anxiety and depression, and develop coping strategies to decrease somatic complaints.

Duration: 12 Months
Frequency: bi-monthly
Intervention: Therapy to coach Billy in utilizing resources that have served to prevent/reduce level of anxiety and improved school attendance.
Duration: 12 Months
Frequency: Bi-monthly

**Intervention:** Collateral services to Billy’s parents to promote and reinforce skills learned in sessions, explore continue strengths and obstacles to improving school attendance.

Duration: 12 Months
Frequency: Bi-monthly

**Intervention:** In-Home Parenting (IHP) to teach appropriate parenting skills, including individual and group sessions.

Duration: 12 Months
Frequency: 1-3x quarterly

**Intervention:** Intensive Home Based Services (IHBS) to assist Billy and parents in developing adaptive coping strategies to minimize anxiety.

**Medical Intervention:** Psychiatrist will evaluate, provide psycho-education regarding medication options/regimen, monitor for changes in symptoms, and potential side effects.

Signature of Parent/Guardian: ____________________________
Date: 1/7/2015

Signature of Client: (75986) TEST, BILLY
Date: 1/7/2015

Client helped develop, understands, agrees with the goals, and has been offered a copy of this client plan.

"If no signature, see progress note dated: ____________________________

Staff ID#: ____________________________
Date: 1/7/2015

Signature of Staff: ____________________________
Date: ____________________________

Signature of Licensed / Waivered Staff: ____________________________
Date: ____________________________

Psychiatrist Signature: ____________________________
Date: ____________________________

**Participants:**

WASHINGTON, GEORGE (000164) - BH Clinician
JEFFERY, JOANN (041932) - BH Clinician, LMFT

The Client Treatment Plan was originally completed by: (041932) JEFFERY, JOANN

Report Run Date: 4/10/2015
Client Treatment Plan Version 2.3 12/17/2014
Confidential Patient Information
See California Welfare and Institutions Code Section 5328
Behavioral Health Progress Note
For (75988) TEST, BILLY
Run Date: 1/6/2015

Service Date: 1/6/2015 Draft/Final Note: Final Note Category: New Service

Patient Name: TEST BILLY 75988
Admit Date: 1/6/2015
Written By: GWASHINGTON
Note Type: Does Not Require Co-signature

Episode: 1
Discharge Date:
Written On: 1/7/2015
Note Time: 03:23 PM

Program service was provided from: CH MH Youth OP
Service Description: ASSESSMENT MH SVC / 3310
Provider: WASHINGTON, GEORGE
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy: Psychoeducation, Supportive Education

Date of Service: 1/6/2015
Duration: 180 minutes
Mins Billed to Client: 180 minutes

Interventions related to objective:
Assessment

Progress Note:
B) I met with Billy and his mother for an initial assessment. 1) I obtained informed consent, reviewed limits of confidentiality, and discussed purpose of mental health services. I conducted a clinical interview to gather information necessary to complete a thorough assessment. R) Billy and his mother were cooperative throughout the session and mother agreed to individual, family, and possibly medication services. She also discussed wanting help with learning parenting skills to address Billy’s symptoms at home. T) Plan is to begin weekly individual sessions to focus on decreasing Billy’s depressive and anxiety symptoms and restoring previous level of functioning; family therapy as needed to assist parents in understanding Billy’s diagnosis and how they can provide support to Billy; will refer for In-Home Parenting services. Will also provide brokerage to school and other service providers as necessary to coordinate care. Mother and Billy are agreeable with plan.

Language Barrier? No
Interpreter Used: No Interpreters Name:
Language: Unknown
Consulted with Primary Care Provider? No
Suicide Risk? Ideation, Intent, Plan
Suicide Comments: Client’s mother reported some recent history of ideation, and intent to shoot self, client has no access to weapons, and is heavily supervised by caregivers. Mother was provided with Crisis Line information, address for CSU, and instructed to call 911 if needed.

Homicide Risk? None
Referrals? Other Professional Provider

Clinician Signature and Discipline

Client Progress Note_Sig and Co-Sig Systems Performance Unit Version 2.5 - 1/2/2015
Confidential Patient Information See California Welfare and Institutions Code Section 5328
Client Name 75988
Client Number
## Behavioral Health Progress Note

**For (75986) TEST BILLY**

**Run Date:** 1/8/2015

**Service Date:** 1/6/2015  
**Draft/Final Note:** Final  
**Note Category:** New Service

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<td>Provider: WASHINGTON, GEORGE</td>
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<tr>
<td>Location: 01 Office / Community MH Center</td>
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<td>Evidence Based Practice / Service Strategy:</td>
</tr>
<tr>
<td>Unknown Evidence-Based Practice / Service Strategy</td>
</tr>
</tbody>
</table>

**Interventions related to objective:**

- Plan Development

**Progress Note:**

D) Gathered assessment information to create a client plan. I) I utilized assessment information to complete a client plan with necessary problems, goals, objectives and interventions based on current symptoms and impairments. R) I utilized information from both Billy and Mother as to how they would know progress was being made to identify client goals. T) Will present client plan to Billy and mother at next session to obtain signatures.

**Language Barrier?** No  
**Interpreter Used:** No  
**Interpreters Name:**  
**Language:** Unknown

**Consulted with Primary Care Provider?** No  
**Suicide Risk?** Not Assessed  
**Homicide Risk?** Not Assessed  
**Referrals?** Unknown

**Clinician Signature and Discipline**

---

**Client Progress Note_Sig and Co-Sig**

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**TEST.BILLY**

**Client Name**  
75986

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**Client Number**

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**Confidential Patient Information**  
See California Welfare and Institutions Code Section 5328

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**Systems Performance Unit**

**Version 2.5 - 1/2/2015**  
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Behavioral Health Progress Note
For (75988) TEST BILLY
Run Date: 1/6/2015

Service Date: 1/6/2015  Draft/Final Note: Final  Note Category: New Service

Patient Name: TEST BILLY  75988  
Admit Date: 1/6/2015  
Written By: GWASHINGTON  
Note Type: Does Not Require Co-signature  
Episode: 1  Discharge Date:  
Written On: 1/7/2015  
Note Time: 03:28 PM

Program service was provided from: CH MH Youth OP
Service Description: INDIVIDUAL MH SVC 38-52 F2f / 3412
Provider: WASHINGTON, GEORGE  
Location: 01 Office / Community MH Center  
Evidence Based Practice / Service Strategy: Age Specific Service Strategy
Date of Service: 1/6/2015  
Duration: 56 minutes  
Mins Billed to Client: 56 minutes

Note Addresses Which Treatment Plan Problem:
Problems-> Billy's symptoms are preventing him from developing appropriate peer relationships.
Goals-> Billy would like to have friends.
Objectives-> Billy will make and maintain at least one new friendship in the next year. Currently Billy has no peer relationships.
Interventions-> Therapist will utilize play therapy to model and teach appropriate social skills

Interventions related to objective:
Play Therapy (Unstructured)

Progress Note:
D) I met with Billy for scheduled individual session. Billy arrived on time to his appointment and was initially hesitant to leave his mother in the waiting room; however, with encouragement from his mother and me, Billy came willingly to the playroom. I encouraged Billy to choose some toys to play with and used open ended questions and reflective listening to encourage communication and continue with rapport building. I read Billy a story about a little bear with depression and encouraged Billy to share his thoughts and feelings with me about the story. R) Billy cooperative throughout the session and chose some cars to play with on the “traffic rug”. Billy listened to the story quietly and looked at the pictures for quite some time. Billy commented that he feels like the bear a lot of the time and doesn’t like feeling this way. T) Will continue working with Billy on building rapport and assisting him in addressing his depressive symptoms. Billy asked if he could return to play with the toys again.

Language Barrier? No
Interpreter Used? No
Interpreters Name: 
Language: Unknown
Consulted with Primary Care Provider? No
Suicide Risk? None
Homicide Risk? None
Referrals? Unknown

Clinician Signature and Discipline

Client Progress Note_Sig and Co-Sig  Systems Performance Unit
Version 2.0 - 1/2/2015
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See California Welfare and Institutions Code Section 5328

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TEST BILLY
Client Name
75988
Client Number
Behavioral Health Progress Note
For (75986) TEST.BILLY
Run Date: 1/9/2015

Service Date: 1/7/2015
Draft/Final Note: Final
Note Category: New Service

Patient Name: TEST BILLY 75986
Admit Date: 1/6/2015
Written By: GWASHINGTON
Note Type: Does Not Require Co-signature

Program service was provided from: CH MH Youth OP
Service Description: COLLATERAL MH SVC / 3110
Provider: WASHINGTON, GEORGE
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy:
Family Psychoeducation, Family Support

Date of Service: 1/7/2015
Duration: 34 minutes
Mins Billed to Client: 34 minutes

Note Addresses Which Treatment Plan Problem:
- Problems: Billy's symptoms are preventing him from developing appropriate peer relationships.
- Goals: Billy would like to have friends.
- Objectives: Billy will make and maintain at least one new friendship in the next year. Currently Billy has no peer relationships.
- Interventions: Collateral services to provide psycho-education regarding client's depressive symptoms, and develop skills with caregivers to support client's goals.

Interventions related to objective:
- Psycho-education, Social Skills

Progress Note:
- D) Scheduled session with Billy's parents. Purpose of session was to increase parent's understanding of Billy's depression and to identify steps they could take to assist Billy in managing these symptoms, as well as ways they could support Billy in building peer relationships. I) I provided educational information regarding depression and how it presents in children. I offered supportive listening and assisted parents in recognizing they are not to blame for Billy's depression or anxiety. I collaborated with parents on ways they could support Billy. I provided role playing activity for them to practice skills in modeling peer relationship building with Billy. R) Parents initially hesitant to engage; however, after identifying and addressing feelings they may be experiencing parents willing to share guilty feelings in relation to Billy's symptoms. Parents then actively engaged and seemed to understand and internalize information that was shared. Parents agreed to talk with Billy about the highs and lows he experiences each day and will encourage him to journal daily using pictures if needed. Parents also initially hesitant to engage in role play activity, but they did engage and were able to see the benefit of modeling this behavior with Billy. T) Will continue with current plan and assisting parents and Billy in understanding nature of depression and how to manage symptoms. Parents will track Billy's efforts in practicing social skills, as well as explore community resources that may provide opportunities for socialization. Will follow-up with Billy and use role playing to model appropriate social skills.
- Suicide Comments: Parents report Billy has had no further incidents of verbalizing wanting to die.

Language Barrier? No
Interpreter Used? No
Interpreters Name:
Consulted with Primary Care Provider? No
Suicide Risk? None
Homicide Risk? None

Client Name
75986
Client Number

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Systems Performance Unit
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Behavioral Health Progress Note
For (75986) TEST BILLY
Run Date: 1/7/2015

Service Date: 1/7/2015
Draft/Final Note: Final
Note Category: New Service

Patient Name: TEST BILLY 75986
Admit Date: 1/6/2015
Written By: GWASHINGTON
Note Type: Does Not Require Co-signature

Admit Date: 1/6/2015
Discharge Date: Written On: 1/7/2015
Note Time: 03:09 PM

Program service was provided from: CH MH Youth OP
Service Description: REHABILITATION MH SVC / 3450
Provider: WASHINGTON, GEORGE
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy:
Unknown Evidence Based Practice / Service Strategy

Date of Service: 1/7/2015
Duration: 56 minutes
Mins Billed to Client: 56 minutes

Note Addresses Which Treatment Plan Problem:
Problems: Billy's symptoms are preventing him from developing appropriate peer relationships.
Goals: Billy would like to have friends.
Objectives: Billy will make and maintain at least one new friendship in the next year. Currently Billy has no peer relationships.
Interventions: Rehabilitation services to teach skill building, practice social skills, and coping skills to manage depressive symptoms.

Interventions related to objective:
Relaxation techniques

Progress Note:
D) Mom brought Billy in for unscheduled appointment and asked if I could meet with Billy to talk about relaxation skills. Billy reports he wasn't able to sleep last night because, "I couldn't make my brain turn off". I invited mom to join session so she could reinforce relaxation skills at home. I talked with Billy about what he was thinking about last night and provided some drawing supplies and encouraged him to draw a picture of what he had been thinking about. I then modeled deep breathing and progressive relaxation and encouraged Billy to follow along. F) Billy drew several different pictures and then said, "My mind is clear". He did a good job of deep breathing and after watching me tense and relax my muscles he tried it. Mom was able to talk Billy through relaxing each part of his body and by the end of the session Billy was almost asleep. T) Mom and Billy agreed to practice relaxation skills this week to see if it helps not only with sleep, but when Billy begins worrying at school.

Language Barrier? No
Interpreter Used: No
Interpreters Name:
Consulted with Primary Care Provider? No
Suicide Risk? None
Homicide Risk? None
Referrals? No Referral Given
Clinician Signature and Discipline

Client Progress Note Sig and Co-Sig
Systems Performance Unit
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Confidential Patient Information
See California Welfare and Institutions Code Section 5328
Behavioral Health Progress Note
For (75986) TEST, BILLY
Run Date: 1/8/2015

Service Date: 1/7/2015 Draft/Final Note: Final Note Category: New Service

Patient Name: TEST BILLY 75986 Admit Date: 1/6/2015
Written By: GWASHINGTON Discharge Date: Written On: 1/7/2015
Note Type: Does Not Require Co-signature Note Time: 03:14 PM

Program service was provided from: CH MH Youth OP Date of Service: 1/7/2015
Service Description: PLAN DEVELOPMENT MH SVC / 3910 Duration: 18 minutes
Provider: WASHINGTON,GEORGE Mins Billed to Client: 18 minutes
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy:
Unknown Evidence-Based Practice / Service Strategy

Interventions related to objective:
Plan Development

Progress Note:
D) Phone call from mom who was upset about a phone call from Billy's teacher. Mother reports teacher was complaining that Billy is not completing his work, is falling asleep at his desk and seems to be isolated. I provided mother an opportunity to discuss her concerns and suggested mom come in later today so she could complete a release of information that would allow me to talk with Billy's teacher to provide education and understanding of Billy's current status. K) Appropriate and appreciative of support. Mother asked if I could talk with Billy's teacher to increase teacher's understanding of Billy's symptoms and how they may impact his classroom performance. T) Mother agreed to come by later this afternoon to complete a release of information. Mom also suggested that we add Billy's other doctors to the release so we could get additional medical records if needed. Will meet with mother later this afternoon to complete authorization. I will follow-up with Billy's teacher once authorization has been completed. Will update Billy's treatment plan if school interactions need to occur more frequently.

Language Barrier? No Interpreter Used: No Interpreters Name: Language: Unknown
Consulted with Primary Care Provider? No
Suicide Risk? Not Assessed
Homicide Risk? Not Assessed
Referrals? Unknown

Clinician Signature and Discipline

1/7/2015

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# Behavioral Health Progress Note

**For (75988) TEST, BILLY**

Run Date: 1/9/2015

<table>
<thead>
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<th>Service Date: 1/7/2015</th>
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<tbody>
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<tr>
<td><strong>Admit Date:</strong> 1/6/2015</td>
<td><strong>Written On:</strong> 1/7/2015</td>
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<td><strong>Written By:</strong> GWASHINGTON</td>
<td><strong>Written On:</strong> 03:17 PM</td>
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<td><strong>Note Type:</strong> Does Not Require Co-signature</td>
<td><strong>Note Time:</strong></td>
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Program service was provided from: CH MH Youth OP

**Service Description:** INFORMATIONAL NOTE / 4010

**Provider:** WASHINGTON, GEORGE

**Location:** 01 Office / Community MH Center

Evidence Based Practice / Service Strategy:

Unknown Evidence-Based Practice / Service Strategy

**Date of Service:** 1/7/2015

**Duration:** 8 minutes

Mins Billed to Client: 8 minutes

**Interventions related to objective:**

Other

**Other Intervention:**

info note

**Progress Note:**

I met with client's mother to explain the Release of Information form and to assist her in completing this document so that I could speak with school personnel. Mother verbalized understanding of the type of information that would be disclosed and to whom and completed necessary paperwork. Will follow up with school staff.

**Language Barrier?** No

**Interpreter Used:** No

**Interpreters Name:**

**Language:** Unknown

**Consulted with Primary Care Provider?** No

**Suicide Risk?** Not Assessed

**Homicide Risk?** Not Assessed

**Referrals?** No Referral Given

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**Clinician Signature and Discipline**

![Signature]

1/7/2015

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**Client Progress Note Sig and Co-Sig**

Client Name

75988

Client Number
# Behavioral Health Progress Note

For (75988) TEST BILLY  
Run Date: 1/6/2015

<table>
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## Program Service Provided:
- CH MH Youth OP
- Service Description: BROKERAGE MH SVC / 3030
- Provider: WASHINGTON, GEORGE
- Location: 01 Office / Community MH Center
- Evidence Based Practice / Service Strategy: Unknown Evidence-Based Practice / Service Strategy

### Date of Service: 1/7/2015
- Duration: 22 minutes
- Mins Billed to Client: 22 minutes

### Note Addresses Which Treatment Plan Problem:
- Problems: Billy's symptoms are preventing him from developing appropriate peer relationships.
- Goals: Billy would like to have friends.
- Objectives: Billy will make and maintain at least one new friendship in the next year. Currently Billy has no peer relationships.
- Interventions: Provide brokerage and linkage to assist client and family in identifying and connecting with age appropriate social activities.

### Interventions related to objective:
- Case Management

### Progress Note:
- D) Phone Call to client's teacher per the request of Mrs. Test. Billy's mother. 1) I spoke with Billy's teacher about Billy's diagnoses and ways she could utilize his strengths to support Billy in the classroom and on campus. I explored Billy's strengths from the teacher's perception and provided active listening. Also explored potential resources on campus that may assist Billy. 2) Teacher reports Billy is helpful in the class in that he follows directions, is creative and seems to be a caring child. She indicated Billy seems awkward around his peers and doesn't seem to know how to interact with his peers. Teacher open to praising Billy's positive traits and also suggested speaking with the school counselor about a referral to a social skills group as this may help Billy feel more at ease with his peers. 3) Will follow-up with Billy's parents and teacher agreed to speak with the school counselor.

### Language Barrier?
- No

### Interpreters Used?
- No

### Language:
- Unknown

### Consulted with Primary Care Provider?
- No

### Suicide Risk?
- Not Assessed

### Homicide Risk?
- Not Assessed

### Referrals?
- No Referral Given

### Clinician Signature and Discipline

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**Client Progress Note, Sig and Co-Sig**

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Confidential Patient Information  
See California Welfare and Institutions Code Section 5328

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<table>
<thead>
<tr>
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**Test Billy**
Behavioral Health Progress Note
For TEST BILLY 75986
Run Date: 1/8/2015

Service Date: 1/7/2015
Draft/Final Note: Final
Note Category: New Service

Patient Name: TEST BILLY 75986
Admit Date: 1/6/2015
Written By: GWASHINGTON
Note Type: Does Not Require Co-signature

Discharge Date: 
Written On: 1/7/2015
Note Time: 03:31 PM

Program service was provided from: CMH Youth OP
Service Description: COLLATERAL MH SVC / 3110
Provider: WASHINGTON, GEORGE
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy:
Family Psychoeducation, Family Support

Date of Service: 1/7/2015
Duration: 64 minutes
Mins Billed to Client: 64 minutes

Note Addresses Which Treatment Plan Problem:
Problems - Billy's symptoms are preventing him from developing appropriate peer relationships.
Goals - Billy would like to have friends.
Objectives - Billy will make and maintain at least one new friendship in the next year. Currently Billy has no peer relationships.
Interventions - Collateral services to provide psycho-education regarding client's depressive symptoms, and develop skills with caregivers to support client's goals.

Interventions related to objective:
Psycho-education

Progress Note:
D) Scheduled session with Billy's parents. Purpose of session was to increase parent's understanding of Billy's depression and to identify steps they could take to assist Billy in managing these symptoms. I) Provided educational information regarding depression and how it presents in children. Offered supportive listening and assisted parents in recognizing they are not to blame for Billy's depression or anxiety. Collaborated with parents on ways they could support Billy. R) Parents initially resistant to engage; however, after identifying and addressing feelings they may be experiencing parents willing to share guilt feelings in relation to Billy's symptoms. Parents then actively engaged and seemed to understand and internalize information that was shared. Parents agreed to talk with Billy about the highs and lows he experiences each day and will encourage him to journal daily using pictures if needed. T) Will continue with current plan and assisting parents and Billy in understanding nature of depression and how to manage symptoms.

Language Barrier? No
Interpreter Used: No
Interpreters Name: 

Language: Unknown
Consulted with Primary Care Provider? No
Suicide Risk? Not Assessed
Homicide Risk? Not Assessed
Referrals? No Referral Given

Clinician Signature and Discipline

Client Progress Note, Sig and Co-Sig
Systems Performance Unit
Version 2.5 - 1/2/2015
Confidential Patient Information
See California Welfare and Institutions Code Section 5328

Client Name
TEST BILLY
Client Number
75986
Behavioral Health Progress Note
For (75986) TEST.BILLY
Run Date: 1/8/2015

Service Date: 1/7/2015  Draft/Final Note: Final  Note Category: New Service
Episode: 1  Discharge Date:  
Written By: GWASHING  Written On: 1/7/2015  Note Time: 03:35 PM
Note Type: Does Not Require Co-signature

Program service was provided from: CH MH Youth OP
Service Description: COLLATERAL GROUP MH SVC / 3112
Provider: WASHINGTON, GEORGE
Location: 01 Office / Community MH Center
Evidence Based Practice / Service Strategy:
Unknown Evidence-Based Practice / Service Strategy

Date of Service: 1/7/2015
Duration: 120 minutes
Mins Billed to Client: 24 minutes
# in Group:

Note Addresses Which Treatment Plan Problem:
- Problems-> Billy's somatic complaints and worry are hindering his ability to attend school
- Goals-> Billy would like to remain at school for the entire day daily.
- Objectives-> Billy will improve school attendance from currently 3 days per week to 5 days per week.

Interventions related to objective:
- Group Therapy, Parenting Education, Psycho-education

Progress Note:
D) In-Home Parenting Collateral Group session with Billy's parents and 4 other group members. Purpose of session was to increase parent's understanding of Billy's separation anxiety and to identify steps they could take to assist Billy in managing these symptoms. I) I provided educational information regarding anxiety and how it presents in children. I reviewed skills taught in previous group session. Facilitated group discussion around using these skills. Taught appropriate use of timeouts both for negative behavior and cool-down periods. R) Parents engaged more in this group than previously. They reported success giving Billy choices, expressing it seems to decrease his anxiety. The expressed feeling positive about using timeouts as cool-down periods, both for Billy and themselves.
T) Parents will attempt using cool-down timeout at least 1x over the next week. Will meet again for Collateral Group next week.

Language Barrier? No
Interpreter Used: No  Interpreters Name:  Language: Unknown
Consulted with Primary Care Provider? No
Suicide Risk? Not Assessed
Homicide Risk? Not Assessed
Referrals? No Referral Given

Clinician Signature and Discipline

Client Progress Note_Sig and Co-Sig
Page 19 of 20

Systems Performance Unit
Version 2.5 - 1/2/2015

Confidential Patient Information
See California Welfare and Institutions Code Section 5328

TEST.BILLY
Client Name
75986
Client Number
## Behavioral Health Progress Note

For (75986) TEST BILLY

Run Date: 1/6/2015

<table>
<thead>
<tr>
<th>Service Date: 1/7/2015</th>
<th>Draft/Final Note: Final</th>
<th>Note Category: New Service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name:</strong> TEST BILLY 75986</td>
<td><strong>Episode:</strong> 1</td>
<td><strong>Discharge Date:</strong></td>
</tr>
<tr>
<td><strong>Admit Date:</strong> 1/6/2015</td>
<td><strong>Written By:</strong> GWASHINGTON</td>
<td><strong>Written On:</strong> 1/7/2015</td>
</tr>
<tr>
<td><strong>Note Type:</strong> Does Not Require Co-signature</td>
<td><strong>Note Time:</strong> 03:02 PM</td>
<td><strong>Location:</strong> 01 Office / Community MH Center</td>
</tr>
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</table>

**Program service was provided from:** CH MH Youth OP

**Service Description:** INTENSIVE CARE COORDINATION ICC-KATIE A / 3040

**Provider:** WASHINGTON, GEORGE

**Evidence Based Practice / Service Strategy:**

- Unknown Evidence-Based Practice / Service Strategy

**Date of Service:** 1/7/2015

**Duration:** 83 minutes

**Mins Billed to Client:** 83 minutes

**Note Addresses Which Treatment Plan Problem:**

- Problems:
  - Billy's symptoms are preventing him from developing appropriate peer relationships.
  - Billy would like to have friends.

- Goals:
  - Billy will make and maintain at least one new friendship in the next year. Currently Billy has no peer relationships.

- Interventions:
  - Intensive care coordination to collaborate with client's other service providers, school, family members and support system.

**Interventions related to objective:**

- Case Management, Parenting Education

**Progress Note:**

D) Met with Billy, his parents, CSD social worker, teacher, and Suzie Smith, BHC for CFT meeting at CSD office to check on progress towards Billy's treatment goals. CFT facilitated by Suzie Smith, BHC. Billy's teacher reports Billy continues to exhibit significant anxiety at school which interferes with his ability to complete tasks. This task completion difficulty negatively impacts Billy at home as well because he gets grounded when he gets a pink slip from his teacher for not completing tasks. I) Worked on identifying anxiety triggers to educate family and teacher. Worked to create visual cues Billy can use with his teacher when he is feeling anxious in class. Explored with teacher methods used to reduce Billy's anxiety in class. Assisted parents in creating a regular communication method with Billy's teacher to reduce conflict at home. R) Billy parents, and teacher were in agreement with plan of action and expressed confidence in the plan. T) Billy's case manager, Tom Fosier, will continue with IHBS after school 3 times per week to assure coordination between parents and teacher is occurring and to increase parenting skills to assist with decreasing Billy's behaviors. Follow-up CFT scheduled in one month to check progress.

**Language Barrier:** No

**Interpolator Used:** No

**Interpreters Name:**

**Language:** Unknown

**Consulted with Primary Care Provider:** No

**Suicide Risk?** Not Assessed

**Homicide Risk?** Not Assessed

**Referrals?** No Referral Given

**Clinician Signature and Discipline**

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Client Progress Note, Sig and Co-Sig

Systems Performance Unit

Version 2.5 - 1/2/2015

Confidential Patient Information

See California Welfare and Institutions Code Section 5328

Client Name

TEST BILLY

Client Number

75986
# Behavioral Health Progress Note

**For (75986) TEST, BILLY**

Run Date: 1/9/2015

## Service Date: 1/7/2015

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<th><strong>Patient Name:</strong></th>
<th>TEST BILLY 75986</th>
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</thead>
<tbody>
<tr>
<td><strong>Admit Date:</strong></td>
<td>1/6/2015</td>
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<tr>
<td><strong>Written By:</strong></td>
<td>GWASHINGTON</td>
</tr>
<tr>
<td><strong>Note Type:</strong></td>
<td>Does Not Require Co-signature</td>
</tr>
<tr>
<td><strong>Program service was provided from:</strong></td>
<td>CH MH Youth OP</td>
</tr>
<tr>
<td><strong>Service Description:</strong></td>
<td>INTENSIVE HOME BASED SVCs IHBS-KATIEA / 3420</td>
</tr>
<tr>
<td><strong>Provider:</strong></td>
<td>WASHINGTON,GEORGE</td>
</tr>
<tr>
<td><strong>Location:</strong></td>
<td>01 Office / Community MH Center</td>
</tr>
<tr>
<td><strong>Evidence Based Practice / Service Strategy:</strong></td>
<td>Psychoeducation, Unknown Evidence Based Practice / Service Strategy</td>
</tr>
</tbody>
</table>

**Date of Service:** 1/7/2015

**Duration:** 92 minutes

**Mins Billed to Client:** 92 minutes

## Note Addresses Which Treatment Plan Problem:

- Problems-> Billy's somatic complaints and worry are hindering his ability to attend school.
- Goals-> Billy would like to remain at school for the entire day daily.
- Objectives-> Billy will improve school attendance from currently 3 days per week to 5 days per week.
- Interventions-> In-Home Parenting (IHP) to teach appropriate parenting skills, including individual and group sessions.

## Interventions related to objective:

- Communication skill-building, Parenting Education, Psycho-education, Role-play to teach communication skills

## Progress Note:

D) Travelled to Billy's home to provide IHP with Billy and Mom. Tom Foolery, BHC was out sick today, so I provided the service. Mom reports Billy is really hard to manage after school as he doesn't want to complete homework and chores and whines incessantly when asked to complete tasks. I) I spoke with Billy about activities he enjoys and modeled appropriate social skills tying this in to having more structured time after school, so he can have some fun time with peers in his neighborhood. Talked with mom about current activities that would be appropriate for Billy's age group and interest and discussed how giving him an outlet for his energy and something to look forward to may assist with improving Billy's mood. Modeled for mom appropriate ways to engage Billy in homework and chores and had mom role play with me to practice first and then had her try with Billy. R) Billy responded to inquiries about activities and indicated he likes chess and basketball. Mom agreed to look into these activities and get Billy signed up. Initially mom was hesitant to try different method of communicating with Billy, but engaged with support. Billy responded well to being given choices and engaged easily in homework and chore task. Mom said, "I didn't know it could be this easy". Mom was agreeable to using these communication skills. Billy agreed to work with mom when she is giving him choices and follow through with tasks. T) Will meet with family 2 additional visits this week to continue providing opportunities to learn healthy coping strategies and improved communication. Mom will take Billy to sign up for a basketball or chess activity.

**Language Barrier?** No

**Interpreter Used?** No

**Interpreters Name:**

**Language:** Unknown

**Consulted with Primary Care Provider?** No

**Suicide Risk?** None

**Homicide Risk?** None

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**Client Progress Note, Sig and Co-Sig**

**Systems Performance Unit**

**Version 2.5 - 1/2/2015**

*Confidential Patient Information* See California Welfare and Institutions Code Section 5328
LPHA
“Licensed Practitioner of the Healing Arts (LPHA)” – In Butte County the following are considered LPHA’s: physicians, licensed/waivered psychologists, licensed/waivered clinical social workers, licensed/waivered marriage & family therapists, and licensed psychiatric nurse practitioner.

PRESCRIBER
A prescriber is someone who holds a license that allows them to prescribe medication. In Butte County, we have MD’s, DO’s, and NP’s who are prescribers. In situations where a client is receiving mental health and medication services a prescriber’s signature must be on the treatment plan.

PULLED FORWARD
In the EHR, documents have been designed so that when a client is opened to a new program staff can “pull forward” information from a previous program, rather than having to manually enter the information. “Pulled Forward” essentially means to “copy” information into the new program. This should only be done when a client is transferring from one program to another and the documentation remains valid. If a document is pulled forward, the person pulling the document forward must attest that they are pulling it forward and not making any changes. If changes are needed to a document, the provider must complete a new document.

SCOPE OF PRACTICE
The definition of scope of practice provided by law delineates what the profession does and places limits upon or confines the breadth of functions persons within a profession may lawfully perform. Scope of practice in Butte County’s Mental Health Plan also incorporates job classification. For example, a staff member in a Behavioral Health Counselor (BHC) position may hold a Master’s Degree in Psychology or Social Work, which technically allows them to diagnose a client; however, diagnosing is not a function within the BHC job classification and therefore is not within the scope of practice for a BHC.

VALID
In the context of this documentation manual, valid refers to the date all of the required information and appropriate signatures have been finalized on an option. For example, an assessment may be started on 5/11/13; however, this assessment isn’t finalized until 6/12/13. In this example the valid date of the assessment is 6/12/13.
 INCLUDED DIAGNOSES

The following DSM-IV-TR disorders qualify for a primary diagnosis:

- Pervasive Developmental Disorders, except Autistic Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and Other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
- Mood Disorders, except Mood Disorders due to a General Medical Condition
- Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorder
- Eating Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders (Axis II), excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorder related to other included diagnoses
EXCLUDED DIAGNOSES
The following DSM-IV-TR disorders do not qualify for a primary diagnosis:

- Autistic Disorder
- Learning Disorders
- Motor Skill Disorders
- Communication Disorders
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Other conditions that may be a focus of clinical attention, except Medication-Induced Movement Disorders
- Mental Retardation (Axis II)
- Antisocial Personality Disorder (Axis II)
- 799.9 Deferred diagnosis
- V71.09 No diagnosis
## BCDBH CHART PAPERWORK TIMELINES

<table>
<thead>
<tr>
<th>NAME OF DOCUMENT</th>
<th>INITIALLY COMPLETED</th>
<th>UPDATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent for Treatment</td>
<td>Obtained the day of the first face-to-face contact.</td>
<td>Annually*</td>
</tr>
<tr>
<td>Advanced Directive (Adults Only)</td>
<td>Discuss with client (complete form if client requests Advanced Directive).</td>
<td>Not Required *</td>
</tr>
<tr>
<td>Member Information Brochure</td>
<td>Given to client on the day of the first face-to-face contact.</td>
<td>Not Required</td>
</tr>
<tr>
<td>Acknowledgement of Receipt of Notice of Privacy Practices</td>
<td>Obtained the day of the first face-to-face contact.</td>
<td>Not required*</td>
</tr>
<tr>
<td>Patients’ Rights Brochure</td>
<td>Offered the day of the first face-to-face contact.</td>
<td>Not Required</td>
</tr>
<tr>
<td>Acknowledgement of Receipt of Medi-Cal Handbook</td>
<td>Offered Medi-Cal Handout the day of the first face-to-face contact.</td>
<td>Not required*</td>
</tr>
<tr>
<td>Pay or Financial Information Form (PFI) – 2 pages</td>
<td>Obtained the day of the first face-to-face contact.</td>
<td>Annually or if situation changes</td>
</tr>
<tr>
<td>Client Registration (Client Demographics Data) – 2 pages</td>
<td>Obtained the day of the first face-to-face contact.</td>
<td>Annually (or if client moves)</td>
</tr>
<tr>
<td>Client CSI Data (CA State Info)</td>
<td>Given to client on the day of the first face-to-face contact.</td>
<td>Annually</td>
</tr>
<tr>
<td>Emergency Contact Information Form</td>
<td>Obtained the day of the first face-to-face contact.</td>
<td>Annually</td>
</tr>
<tr>
<td>Release of Information (Authorization for Use or Disclosure of Protected Health Information)</td>
<td>As needed to obtain, disclose, or exchange protected health information.</td>
<td>Annually (unless otherwise specified in release or updated as needed)</td>
</tr>
<tr>
<td>Episode Opening and Period Information/Last Page of Assessment (For Contract Providers only)</td>
<td>Completed at first visit.</td>
<td>Annually or rewritten to update changes</td>
</tr>
<tr>
<td>Assessment Bundle</td>
<td>Within 60 days of opening.</td>
<td>Annually – May be updated as needed</td>
</tr>
</tbody>
</table>

* Unless legal status changes – i.e. Youth turns 18 or conservatorship or ward/dependent of the court, etc.
<table>
<thead>
<tr>
<th>NAME OF DOCUMENT</th>
<th>INITIALLY COMPLETED</th>
<th>UPDATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Treatment Plan</td>
<td>No later than 60 days from opening date. <strong>Until a client plan is finalized with necessary signatures, the only services that can be provided are assessment, plan development, and crisis intervention.</strong></td>
<td>Annually – May be updated at any time</td>
</tr>
<tr>
<td>Progress Notes</td>
<td>For each client contact.</td>
<td>N/A</td>
</tr>
<tr>
<td>Consent for Psychotropic Medication Therapy</td>
<td>By M.D. or prescribing nurse when medication is prescribed.</td>
<td>Completed when a new medication is added</td>
</tr>
<tr>
<td>Medication Order Sheet</td>
<td>By M.D. or prescribing nurse when medications are prescribed.</td>
<td>Whenever meds are added, refilled, or discontinued</td>
</tr>
<tr>
<td>Therapeutic Behavioral Services (TBS) Referral</td>
<td>When a client who is eligible is referred.</td>
<td>N/A</td>
</tr>
<tr>
<td>Client Discharge</td>
<td>Complete at time of last service with client to close or transfer case. Discharge diagnosis is entered as well as completing MyAvatar Discharge option</td>
<td>N/A</td>
</tr>
<tr>
<td>NOA (A B C D E )</td>
<td>Complete NOA in MyAvatar when client meets criteria (See NOA Summary)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Forms in all sections should be in chronological order with the most current on top*
3030 **BROKERAGE/TARGETED CASE MANAGEMENT**: services that assist a beneficiary to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities include: 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.

3110 **COLLATERAL**: services to one or more significant support persons in the life of the client for the purpose of improving or maintaining the mental health of the client. Progress notes must address the goals and interventions on the client plan.

3112 **GROUP COLLATERAL**: services provided to a group of ‘significant support persons’ of client’s receiving direct mental health services. Client is not present. Used primarily in relation to youth (under 18 clients) - though not exclusively. The group activity is education and interventions that help the significant support people improve the client’s functional impairments and/or assist in minimizing the impact of mental illness on client functional impairments. The primary focus cannot be support for the parent, significant other, etc. Progress notes should include the number of clients represented - not the number of significant support people who are present. Example: there are 7 significant support people present in the group, but they represent 5 clients. The note would reflect 5 clients were benefitting from the group. Progress notes must address the goals and interventions on the client plan.

3310 **ASSESSMENT AND EVALUATION**: service activity with a client that formulates a clinical analysis of the history and current status of the client’s mental, emotional, or behavioral disorder, including relevant cultural issues. Assessment may include diagnosis and testing procedures (includes performance outcome measures).
**INDIVIDUAL THERAPY:** face-to-face (F2F) service time (client is present) is from 1 - 37 minutes. Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments. Can include ‘Family Therapy’ with client present. Progress notes must address the goals and interventions on the client plan.

**INDIVIDUAL THERAPY:** F2F service time (client is present) is from 38 - 52 minutes. Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments. Can include ‘Family Therapy’ with client present. Progress notes must address the goals and interventions on the client plan.

**INDIVIDUAL THERAPY:** F2F service time (client is present) is from 53 - 480 minutes. Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments. Can include ‘Family Therapy’ with client present. Progress notes must address the goals and interventions on the client plan.

**INDIVIDUAL THERAPY:** a “non face-to-face” direct service activity (the client is not physically present – perhaps telephone, etc.). Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments. Can include ‘Family Therapy’ with client present. Progress notes must address the goals and interventions on the client plan.

**REHABILITATION SERVICES:** counseling and other services with a client which address functional impairments: improve, maintain, or restore a functional skill, daily living skill, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication education. Progress notes must address the goals and interventions on the client plan.

**GROUP THERAPY:** services provided to a group of clients that focus on symptom reduction as a means to improve functional impairment. Progress notes must include the number of clients in the group and address the goals and interventions on the client plan.

**GROUP REHABILITATION SERVICES:** services provided to a group of clients which address functional impairments: improve, maintain, or restore a functional skill, daily living skill, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication education. Progress notes must include the number of clients present and address the goals and interventions on the client plan.

**CRISIS INTERVENTION:** “face-to-face” (F2F) service time (client physically present) is between 1-44 minutes. Unplanned services that require a more
timely response than a regularly scheduled visit. Progress notes need not address the client plan goals and interventions; notes must document the nature and severity of the crisis, staff interventions to manage the crisis, and follow-up plans. Multiple contacts may be documented in a single note and contacts with collateral individuals may be included.

CRISIS INTERVENTION: a “non face-to-face” direct service activity (the client is not physically present - perhaps telephone, etc.). Unplanned services that require a more timely response than a regularly scheduled visit. Progress notes need not address the client plan goals and interventions; notes must document the nature and severity of the crisis, staff interventions to manage the crisis, and follow-up plans. Multiple contacts may be documented in a single note and contacts with collateral individuals may be included.

PLAN DEVELOPMENT: service activity, which consists of the development of client plans, the approval of client plans, and/or monitoring of a beneficiary’s progress. Progress notes should state that the client plan goals and interventions were developed, updated, progress toward the goals, or how the interventions will be implemented.
**PROCEDURE CODES FOR MEDICAL STAFF**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>3610</td>
<td><strong>MEDICATION SUPPORT</strong>: a “non face-to-face” direct service activity (the client is not present). This code is used primarily for two Medi-Cal claimable activities: developing and writing a medication client plan (med support Plan Development); or medication monitoring services including review of recent lab reports, medication renewal orders, etc.</td>
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<tr>
<td>3630</td>
<td><strong>MEDICATION SUPPORT- MENTAL HEALTH SERVICE</strong> non-prescriber code: F2F service time (client physically present) This code is to be used by non-prescribing medical staff for ongoing assessment, administration of medications, etc.</td>
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<tr>
<td>90792</td>
<td><strong>ASSESSMENT MHS SERVICES W/MEDICAL SERVICES</strong>: “face-to-face” (F2F) service time (client physically present) Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. – The evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies. Diagnostic Evaluation/Assessment MH Svc w/ Medical Services (old = 90801)</td>
</tr>
<tr>
<td>99213</td>
<td><strong>MEDICATION SUPPORT- MENTAL HEALTH SERVICE</strong> Evaluation/Management for Established Patients – Detail History/Examination for mild to moderate complexity (primary care level or stable mentally ill) (old 90804, 90806, 90808): <strong>MEDICATION SUPPORT</strong>: F2F service time (client physically present). This code is to be used by psychiatrists and Family Nurse Practitioners (individuals who have prescriptive authority) for ongoing assessment, prescription, administration of medications, etc.</td>
</tr>
<tr>
<td>99214</td>
<td><strong>MEDICATION SUPPORT- MENTAL HEALTH SERVICE</strong> Evaluation/Management for Established Patients – Comprehensive History/Examination for moderate to severe complexity (unstable chronically mentally ill) (otherwise the same as 99213)</td>
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<tr>
<td>90833</td>
<td><strong>PSYCOTHERAPY 1-37 MINUTES</strong> Add on code (added to 99213/99214 if psychotherapy was included). From old above (crossed out) “but also includes a substantial psychotherapy component.”</td>
</tr>
<tr>
<td>90836</td>
<td><strong>PSYCOTHERAPY 38-52 MINUTES</strong> Add on code (added to 99213/99214 if psychotherapy was included). From old above (crossed out) “but also includes a substantial psychotherapy component.”</td>
</tr>
</tbody>
</table>
90838  PSYCHOTHERAPY 53 - 1440 MINUTES Add on code (added to 99213/99214 if psychotherapy was included). From old above (crossed out) “but also includes a substantial psychotherapy component.”

M0064  MEDICATION SUPPORT Brief (1-15 minutes) – F2F service time (client physically present) is between 1-15 minutes. This code is to be used by any licensed medical staff (MD, FNP, RN, LVN, LPT) where the primary purpose includes ongoing assessment, prescription, administration of medications, etc.
**PROCEDURE CODES FOR SPECIAL POPULATIONS**

**3230**  
**THERAPEUTIC BEHAVIORAL SERVICES (TBS):** This includes all services relating to TBS including direct service, plan development, and collateral contacts with the family. Progress notes must address the goals and interventions on the TBS client plan. One note per shift. This code is used primarily by contractors providing TBS and should not be used by clinicians who are responsible for delivering the mandatory co-occurring mental health services (therapy, rehab, etc.).

**3040**  
**INTENSIVE CARE COORDINATION (ICC) – KATIE A:** intensive care coordination (ICC) is a targeted case management (TCM) service that facilitates assessment of, care planning for and coordination of services, including urgent services for members of Katie A. Subclass (see Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services & Therapeutic Foster Care for Katie A. Subclass Members – Appendix D (pg 22) in the Manual for a more detailed description of ICC).

**3420**  
**INTENSIVE HOME BASED SERVICES (IHBS) – KATIE A:** intensive home-based mental health services (IHBS) are mental health rehabilitation services provided to members of the Katie A. Subclass. IHBS are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child/youth’s functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth’s family ability to help the child/youth successfully function in the home and community (see Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services & Therapeutic Foster Care for Katie A. Subclass Members – Appendix D (pg 26) in the Manual for a more detailed description of IHBS).
The following service codes capture direct service activity delivered in settings that do not allow conventional funding stream billing (Medi-Cal, etc.) including Juvenile Hall, Jail, Psychiatric Inpatient Hospitals, etc. Staff should use these codes only after approval and consultation with their Program Manager/Clinical Supervisor.

6030  **(NO MCAL) BROKERAGE/TARGETED CASE MANAGEMENT:** Services that assist a beneficiary to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities include: 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.

6110  **(NO MCAL) COLLATERAL:** Services to one or more significant support persons in the life of the client for the purpose of improving or maintaining the mental health of the client. Progress notes must address the goals and interventions on the client plan.

6300  **(NO MCAL) ASSESSMENT AND EVALUATION:** Service activity with a client that formulates a clinical analysis of the history and current status of the client’s mental, emotional, or behavioral disorder, including relevant cultural issues. Assessment may include diagnosis and testing procedures (includes performance outcome measures).

6410  **(NO MCAL) INDIVIDUAL THERAPY (1-37 MINUTES F2F):** Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments; includes Family Therapy with client present. Progress notes must address the goals and interventions on the client plan.

6412  **(NO MCAL) INDIVIDUAL THERAPY (38-52 MINUTES F2F):** Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments; includes Family Therapy with client present. Progress notes must address the goals and interventions on the client plan.
6414  (NO MCAL) INDIVIDUAL THERAPY (53+ MINUTES F2F): Therapeutic interventions with a client that focus primarily on symptom reduction as a means to improve functional impairments; includes Family Therapy with client present. Progress notes must address the goals and interventions on the client plan.

6415  (NO MCAL) INDIVIDUAL THERAPY (NON FACE-TO-FACE): Therapeutic interventions with a client not physically present (telephone, etc.) that focus primarily on symptom reduction as a means to improve functional impairments; includes Family Therapy when client not present. Progress notes must address the goals and interventions on the client plan.

6450  (NO MCAL) REHABILITATION SERVICES: Counseling and other services with a client which address functional impairments: improve, maintain, or restore a functional skill, daily living skill, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication education. Progress notes must address the goals and interventions on the client plan.

6510  (NO MCAL) GROUP THERAPY: Services provided to a group of clients that focus on symptom reduction as a means to improve functional impairment. Progress notes must include the number of clients in the group and address the goals and interventions on the client plan.

6570  (NO MCAL) GROUP REHABILITATION SERVICES: Services provided to a group of clients which address functional impairments: improve, maintain, or restore a functional skill, daily living skill, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and/or medication education. Progress notes must include the number of clients present and address the goals and interventions on the client plan.

6630  (NO MCAL) MEDICATION SUPPORT:

6710  (NO MCAL) CRISIS INTERVENTION (1-74 MINUTES F2F): Unplanned services that require a more timely response than a regularly scheduled visit. Progress notes need not address the client plan goals and interventions; notes must document the nature and severity of the crisis, staff interventions to manage the crisis, and follow-up plans. Multiple contacts may be documented in a single note and contacts with collateral individuals may be included.

6715  (NO MCAL) CRISIS INTERVENTION: (NON FACE-TO-FACE): Unplanned services that require a more timely response than a regularly scheduled visit but the client is not physically present (telephone, etc.) Progress notes need not address the client plan goals and interventions; notes must document the
nature and severity of the crisis, staff interventions to manage the crisis, and follow-up plans. Multiple contacts may be documented in a single note and contacts with collateral individuals may be included.

(NO MCAL) PLAN DEVELOPMENT: Service activity, which consists of the development of client plans and the approval of client plans. Progress notes should state that the client plan goals and interventions were developed, updated, progress toward the goals, or how the interventions will be implemented.
### PROCEDURE CODES DEFINITIONS – INDIRECT SERVICES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4000</td>
<td><strong>NO SHOW</strong>: to be used when a client is scheduled and does not show up at the appointment time. Essentially an “information note” attached to a client record. Staff may use up to 15 minutes to account for this incident.</td>
</tr>
<tr>
<td>4010</td>
<td><strong>INFORMATIONAL NOTE</strong>: documentation of a client interaction or activity that cannot be accounted for as a direct service, but needs to be included in the client record.</td>
</tr>
<tr>
<td>4060</td>
<td><strong>CLIENT SUPPORT</strong>: an activity or contact not eligible to be reported as treatment or outreach. Support may include housing support, recreation, respite care or social support that does not fall under 2410 Day Treatment Socialization. This code is used when other available codes have been ruled out.</td>
</tr>
<tr>
<td>4110</td>
<td><strong>MH PROMOTION</strong>: any activity that informs, educates, clarifies, etc. mental health services to the <em>general public</em> or <em>to other agencies</em>. Not to be used instead of 4780.</td>
</tr>
<tr>
<td>4210</td>
<td><strong>COMMUNITY CLIENT SERVICE (NON-OPENED CASES)</strong>: activities directed toward: 1) assisting clients and families for whom there is no open case record to achieve a more adaptive level of function through single contact or occasional contact, or 2) enhancing or expanding the knowledge and skills of human service agency staff in meeting the needs of mental health clients.</td>
</tr>
<tr>
<td>4250</td>
<td><strong>CRISIS “ON DUTY”</strong>: used to record time spent on the crisis line and as backup counselor when no other activity code can be used to capture this time.</td>
</tr>
<tr>
<td>4270</td>
<td><strong>CRISIS STABILIZATION INFO NOTE</strong>: documentation of a client interaction or activity that cannot be accounted for as a direct service, but needs to be included in the client record. No specific staff time is included.</td>
</tr>
<tr>
<td>4421</td>
<td><strong>SUPERVISION OF STUDENT INTERNS</strong>: to be used by clinical line staff for direct time spent in oversight of student intern activity.</td>
</tr>
<tr>
<td>4560</td>
<td><strong>PHF ON DUTY</strong>: used to account for staff time when they have been temporarily assigned to work a shift on the PHF.</td>
</tr>
</tbody>
</table>
4580 **CSU ON DUTY**: used to account for staff time when they have been temporarily assigned to work a shift on the CSU.

4770 **SAMHSA ACTIVITIES**: SAMHSA related activities not eligible to be reported as treatment or outreach which are provided by staff supported by the general SAMHSA grant. This code identifies staff time that should be billed to the grant.

4780 **GENERAL ADMINISTRATIVE ACTIVITIES**: used to record any non-client billable activity that is not captured in any other indirect code.

4790 **TIME OFF**: any time off, whether paid or Leave Without Pay.

4890 **“MEDI-CAL QUALITY” MANAGEMENT**: used to record time directly related to the Utilization Review activities in association with, and under the direction of, Quality Management (QM)/Quality Improvement (QI) programs (e.g. participation in monthly QM/QI Committees, inpatient & outpatient authorizations, audits, and assigned QA activities).
<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4970</td>
<td>MHSA Community Support Services (CSS): Activities, non-direct Mental Health Service, within approved MHSA programs.</td>
</tr>
<tr>
<td>4971</td>
<td>MHSA Workforce Education Training (WET)</td>
</tr>
<tr>
<td>4972</td>
<td>MHSA Prevention &amp; Early Intervention (PEI)</td>
</tr>
<tr>
<td>4973</td>
<td>MHSA Capitol Information Technology (CapIT)</td>
</tr>
<tr>
<td>4974</td>
<td>MHSA Housing</td>
</tr>
</tbody>
</table>
Appendix D

FORMAT FOR PROGRESS NOTES

DESCRIBE

1. WHAT WAS THE REASON OR PURPOSE OF THE ENCOUNTER?
   - Start by describing the type of service e.g. individual, collateral, etc.

2. WHAT WAS THE CONTENT OR TOPICS DISCUSSED?
   - Factual, brief, and relevant to the goals and objectives if possible

3. WHAT CLINICAL OBSERVATIONS WERE MADE?
   - Should be objective, factual, and non-judgmental

4. WHAT IS THE CURRENT MEDICAL NECESSITY FOR SERVICES?
   - Please remember we need to demonstrate continued medical and service necessity for the level of services that are provided
   - Was the service provided appropriate to address the client’s service need?

5. WHAT WAS SAID, DONE OR REQUESTED BY THE CLIENT?
   - This is a good place to address requests for linguistic services

INTERVENTION

1. WHAT DID YOU DO IN THE CONTEXT OF THE ENCOUNTER?
   - Example: Address what was done about the request for linguistic services cited above

2. WHAT THERAPEUTIC INTERVENTIONS OR TECHNIQUES WERE EMPLOYED?
   - These hopefully reflect the ones listed in the client plan, if not address why there was a deviation from the plan
3. WHAT PROGRESS OR SETBACKS OCCURRED?
   - Describe in measurable, behavioral terms progress toward the goal and address possible reason for lack of progress

4. WHAT REFERRALS WERE MADE?
   - If any referrals were made, please address them here

**RESPONSE**

1. WHAT WAS THE CLIENT’S RESPONSE TO THE INTERVENTION?
   - Address this in specific terms based on behavior or client report

2. HOW WAS THE INTERVENTION EFFECTIVE OR INEFFECTIVE?
   - Describe in terms of measurable or observable changes in behavior whenever possible

3. WHAT SIGNS OR SYMPTOMS OF THE DIAGNOSIS ARE PRESENT OR NO LONGER PRESENT?
   - This goes to medical necessity and accuracy of current treatment

4. WHAT WAS DONE OUTSIDE THE SESSION?
   - If homework was given at the previous session this is a good place to address what the client did or did not accomplish
   - If the client self-initiated any interventions, report them as well (e.g. joining a self-help group)

5. WHAT ARE THE CLIENT’S CURRENT IMPAIRMENTS AND STRENGTHS?
   - Again, this addresses medical and service necessity and should describe current levels of functional impairments and strengths to overcome them

**TREATMENT PLAN**

1. HOW DID THE SESSION ADDRESS TREATMENT PLAN OBJECTIVES?
   - Based on what was described above, describe how you helped the client’s the recovery process

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2. WHAT WILL BE DONE OUTSIDE THE SESSION?
   - Describe any activities that will occur before the next contact, e.g. planned, referrals, etc.

3. WAS THERE HOMEWORK ASSIGNED?
   - Did you teach the client a new adaptive skill and is there an expectation that it will be practiced before the next session

4. WHAT TYPE OF FOLLOW UP WILL BE MADE?
   - Similar to above, could consist of planned collateral contacts. State the planned time for the next contact with the client
### BILLING LOCK-OUT GRID

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>Lock-out Mental Health Service</th>
<th>Lock-out Medication Support Services</th>
<th>Lock-out Targeted Case Management Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Site or During the Hours of Operation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Residential</td>
<td>Yes¹</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Crisis Stabilization (CSU)</td>
<td>Yes²</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day Programs (Intensive and Rehabilitation)</td>
<td>No³</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Juvenile Hall, Jail, or Similar Detention (not adjudicated for Placement)</td>
<td>Yes⁴</td>
<td>Yes³</td>
<td>Yes³</td>
</tr>
<tr>
<td>Psychiatric Inpatient Hospital</td>
<td>Yes¹, ⁴</td>
<td>Yes</td>
<td>Yes⁴</td>
</tr>
<tr>
<td>Psychiatric Health Facility (PHF)</td>
<td>Yes¹</td>
<td>Yes</td>
<td>Yes⁵</td>
</tr>
<tr>
<td>Psychiatric Nursing Facility</td>
<td>Yes¹</td>
<td>Yes</td>
<td>Yes⁵</td>
</tr>
<tr>
<td>Physical Health Care Hospital</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

For ICC and IHBS, see Medi-Cal Documentation Manual for lock-outs

³ Except on the day of admission
² No other Specialty Mental Health Service is reimbursable during the same time period the service is reimbursed
³ Except by the same Day Treatment Program Staff
⁴ Except on the day of admission, and 30 calendar days or less per continuous stay in the facility immediately prior to discharge for the purpose of placement
⁵ Except on the day of admission, and 30 calendar days immediately prior to the day of discharge, for a maximum of three non-consecutive periods of 30 calendar days or less per continuous stay in the facility immediately prior to discharge for the purpose of placement.

*Adapted from CIMH EPSDT Manual Lock-Out Crosswalk (Lisa Scott-Lee, 2007)