SUD Treatment Progress Note Instructions

REQUIRED FORM:

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

WHY:

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

WHEN:

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

This form must be completed within the 3 business days (day of service + 2 business days), or 24 hours for crisis services, as directed in DHCS Information Notice 22-019.

COMPLETED BY:

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

RESIDENTIAL PROGRAMS:

Only one note is required for a bed day to summarize the client's services; however, separate notes must be written for Peer Support Specialist Services, Case Management or Clinical Consultation. All notes should still contain all the elements below.

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

- **Client Name:** Complete client's full name.
- **Client ID:** Complete the client ID number as determined by agency guidelines.
- **Date:** Complete date of the service.
- **Total Service Time in minutes (optional)**
- **Total Documentation Time in minutes (optional)**
- **Total Travel Time in minutes (optional)**
- **Total Time (including: service, documentation, travel) in minutes**
    - Note: If billing a bed day, enter "bed day" in this field
- **Language of Service (if other than English)**
- **Translator Utilized (if applicable)**

- **Location of Beneficiary at the Time of Service**: Refer to reference page for codes and location descriptions and select appropriate code from drop-down list.
- **Contact Type** (F-F = face to face, TEL = Telephone, TH = Telehealth, COM = In Community)
- **Service Type** (IND = Ind. Counseling, GR = Group Counseling, CC = Care Coordination, MAT = Medication Assisted Treatment, CLC = Clinician Consultation)
- **EBP Utilized** (progress note must document specifics of how EBP was utilized the narrative)

Progress Note Narrative Section: A complete progress note addresses:

1. A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors).
2. Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.
3. Best practice is to include clear documentation of how evidence-based practices were used in the service provided.

Telehealth Consent: Documentation of client consent to receive services via telehealth of telephone must be documented, and may include documentation of verbal consent. A one-time consent in the client file is considered sufficient.

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

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