SMHS Documentation Requirements: Part 2

Alameda County Health

Behavioral Health Department

Quality Management

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Topics

- Assessments
- Problem Lists
- Progress Notes
- Risk Assessments and Safety Plans
- Plan Development
- Resources

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Assessments

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Assessments: General

- Assessment is a service activity that evaluates the current status of a member's mental, emotional, or behavioral health.
- Assessments may only be ***completed*** by providers with the Scope of Practice to do so, which requires specialized training and education. Only providers in the LMHP category may complete an assessment.
- Non-licensed providers can gather clinical information that can later be used by an LMHP to complete an assessment.
- Assessment activities may include meeting with a member and establishing rapport, gathering information to help get to know the member, and collecting details about their medical history, cultural and social health information, and reasons for seeking support, etc.
- This process also provides a valuable opportunity for relationship building with members.

Assessments: General (Cont'd)

- Assessments should be completed within a **reasonable timeframe** following the start of services - typically within 30-60 days.
- Assessments must be **updated** when new information is obtained that will likely change the treatment approach or services provided.
- LMHPs must complete a uniform assessment that includes specific information categorized in Domains established by the California Department of Health Care Services (DHCS).
- Although there is no penalty for documenting relevant information outside the specific Domains, using a well-organized format allows for less overlap and more easily locating and referring back to important information.

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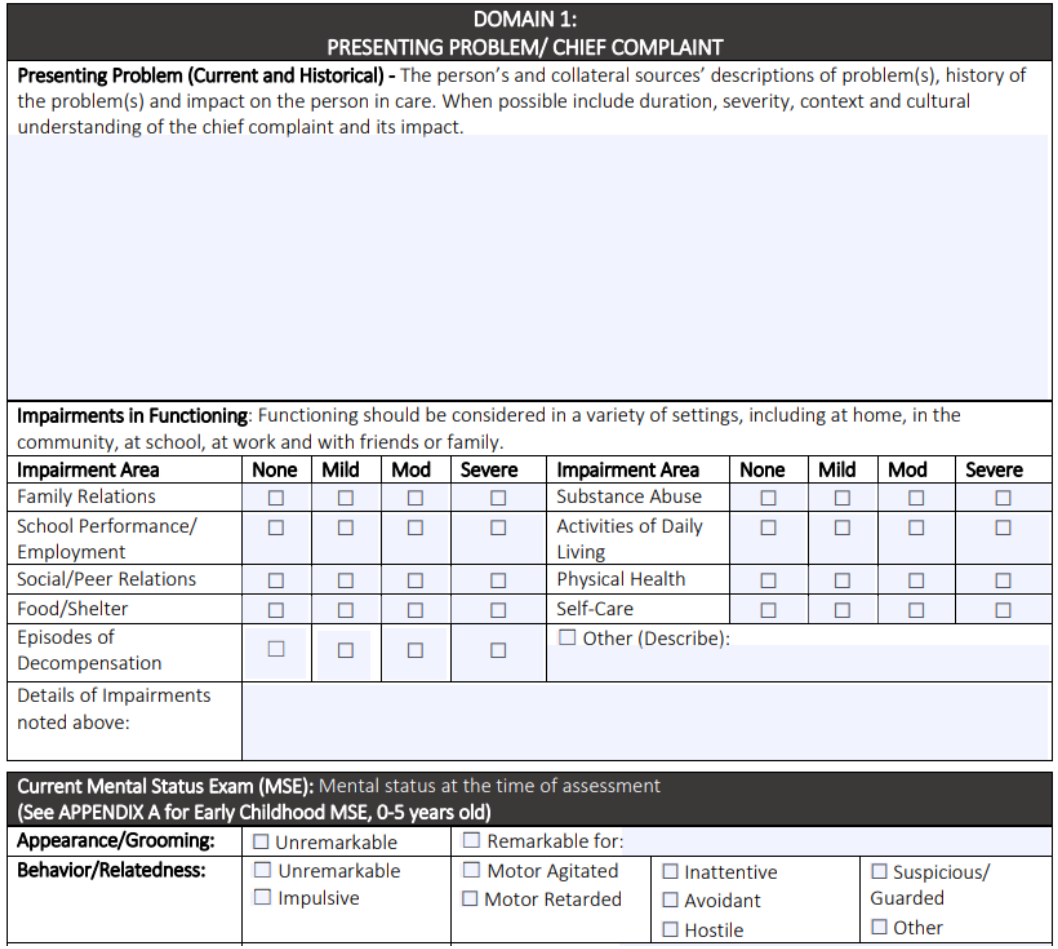
Assessment Domains

Domain	Details
Domain 1. Presenting Problem	Includes current and historical data detailing what led the person to seek care.
Domain 2. Trauma	Includes exposure, screenings, and impact.
Domain 3. Behavioral Health History	Includes mental health and substance use experiences, and treatment history.
Domain 4. Medical History	Includes physical health history, medications, and developmental history.
Domain 5. Psychosocial	Includes family, social, life, educational, vocational, and cultural considerations.
Domain 6. Strengths, Risk and Protective Factors	This domain may also include specific safety screenings depending on the member's presentation.
Domain 7. Clinical Formulation	Includes a well-articulated clinical summary with information supporting diagnostic impressions, and treatment recommendations.

Assessment Template

- ACBHD has designed an Assessment Template that includes prompts for all required information.
- While not required, we **recommend** using this template or one that is similarly organized.
- Paying close attention to the organization of information helps avoid duplication of information and ensures all domains are sufficiently covered.
- The Assessment Template is available in Word and PDF forms on the ACBHD Provider Website and in the **county EHR: Clinician's Gateway.**



DOMAIN 1:
PRESENTING PROBLEM/ CHIEF COMPLAINT

Presenting Problem (Current and Historical) - The person's and collateral sources' descriptions of problem(s), history of the problem(s) and impact on the person in care. When possible include duration, severity, context and cultural understanding of the chief complaint and its impact.

Impairments in Functioning: Functioning should be considered in a variety of settings, including at home, in the community, at school, at work and with friends or family.

Impairment Area	None	Mild	Mod	Severe	Impairment Area	None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
School Performance/ Employment	☐	☐	☐	☐	Activities of Daily Living	☐	☐	☐	☐
Social/Peer Relations	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Food/Shelter	☐	☐	☐	☐	Self-Care	☐	☐	☐	☐
Episodes of Decompensation	☐	☐	☐	☐	☐ Other (Describe):				
Details of Impairments noted above:									

Current Mental Status Exam (MSE): Mental status at the time of assessment
(See APPENDIX A for Early Childhood MSE, 0-5 years old)

Appearance/Grooming:	☐ Unremarkable	☐ Remarkable for:		
Behavior/Relatedness:	☐ Unremarkable ☐ Impulsive	☐ Motor Agitated ☐ Motor Retarded	☐ Inattentive ☐ Avoidant ☐ Hostile	☐ Suspicious/ Guarded ☐ Other

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Assessing for Specialized Intensive Services

- Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) are required to be provided to youth under the age of 21 who are eligible for full scope Medi-Cal and who meet medical necessity criteria.
- Providers are **required** to complete an **individualized screening** for these services and document their findings in the comprehensive assessment.
- The ACBHD Assessment Template has an *Intensive Service Needs Assessment* embedded in Appendix B.
- Providers are encouraged to build a similar template in their own Electronic Health Record systems if not using these standardized forms.

Intensive Service Needs Assessment: ICC/IHBS/TFC		
All beneficiaries with full-scope Medi-Cal under 21 years old must be assessed to determine if they qualify for and need any of the following: Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC). Links to Referral Forms in English are provided below. For Referral Forms in Spanish, use this website: Child & Youth Services – Alameda County Behavioral Health (acbhcs.org) Based upon the clinical assessment, indicate if any of the services below are needed:		
Intensive Care Coordination (ICC) is needed and cannot be adequately provided under standard mental health case management services.	☐ Yes ☐ No ☐ Already Connected	If checked, referral required ICC Referral Form
Intensive Home-Based Services (IHBS) are needed to assist the child/youth in building the skills necessary to successfully function at home and in the community and to assist their family in supporting the child/youth in achieving this goal. These services cannot be adequately provided under standard mental health case management services.	☐ Yes ☐ No ☐ Already Connected	If checked, contact the ICC provider listed on the face sheet to recommend IHBS at next Child and Family Team Meeting (CFT)
Therapeutic Foster Care (TFC) services are needed to address the child/youth's severe emotional issues by providing intensive therapeutic and behavior management services in an in-home, family-based care setting.	☐ Yes ☐ No ☐ Already Connected	If checked, contact the Child and Family Team facilitator (from ICC, Child Welfare, or Probation) to make the recommendation for TFC

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Assessing for Specialized Intensive Services (Cont'd)

As a provider you are **required to assess for need** and **eligibility** for specialized intensive services and coordinate a **referral** to these services as needed. However, you will **not** be providing the services.

Services	Provider Referral Process
Intensive Care Coordination (ICC)	Complete the ICC Referral Form
Intensive Home-Based Services (IHBS)	Contact the ACBHD ICC/IHBS Coordinator at (510) 383-5128.
Therapeutic Foster Care (TFC)	Coordinate with the assigned Child Welfare Worker. TFC services and the TFC referral process are managed by the Alameda County Social Services Agency.

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Additional Assessment Requirements for Youth

In addition to a clinical assessment, providers must complete the below tools by **day 60** of treatment, **every 6 months** (within the calendar month prior to the episode opening date), and at **discharge**.

CANS
(Child and Adolescent Needs and Strengths)

- The CANS is a multi-purpose tool that supports clinical decision making and treatment planning.
- It should be completed for members from birth to 21 years of age.
- Providers must be certified by the Praed Foundation prior to administering the CANS.

PSC-35
(Pediatric Symptom Checklist)

- Brief screening questionnaire that helps identify psychosocial challenges and improve treatment.
- Parents/caregivers will complete the PSC-35 for their children 3 up to 18 years of age.
- In lieu of the PSC-35, the PSC Youth Version (Y-PSC) can be completed by members 11 years of age or older.
- If either version of the PSC is not completed, there should be documentation outlining the barriers to completion.

Knowledge Check: Assessments

According to Medi-Cal regulations, an individual must have a full clinical assessment before they can be admitted to a program.

- ❑ True
- ❑ False

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Knowledge Check- Answer

According to Medi-Cal regulations, an individual must have a full clinical assessment before they can be admitted to a program.

- ❑ True
- ✓ **False**

Review

- Individuals seeking SMHS must be screened to determine whether they meet the Access Criteria, but a full clinical assessment is not required prior to admission.
- Assessments must be completed within a **reasonable timeframe** following the start of services.
- Assessments must be **updated** when new information is obtained that will likely change the treatment approach or services provided.
- Non-licensed providers can gather clinical information that can later be used by an LMHP to complete an assessment.

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Problem Lists

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Problem List

- Providers must create and maintain a **stand-alone** Problem List for all members.
- A Problem List is a **codified** list of an individual's medical, mental health and psychosocial issues.
- It includes relevant diagnoses, acute and chronic conditions, and functional limitations.
- The Problem List should be created at the **start** of treatment and **updated** throughout treatment to reflect a member's most current challenges.
- Conditions should be added or noted as resolved when relevant changes occur.

Source: DHCS BHIN 23-068

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Problem List: Required Information

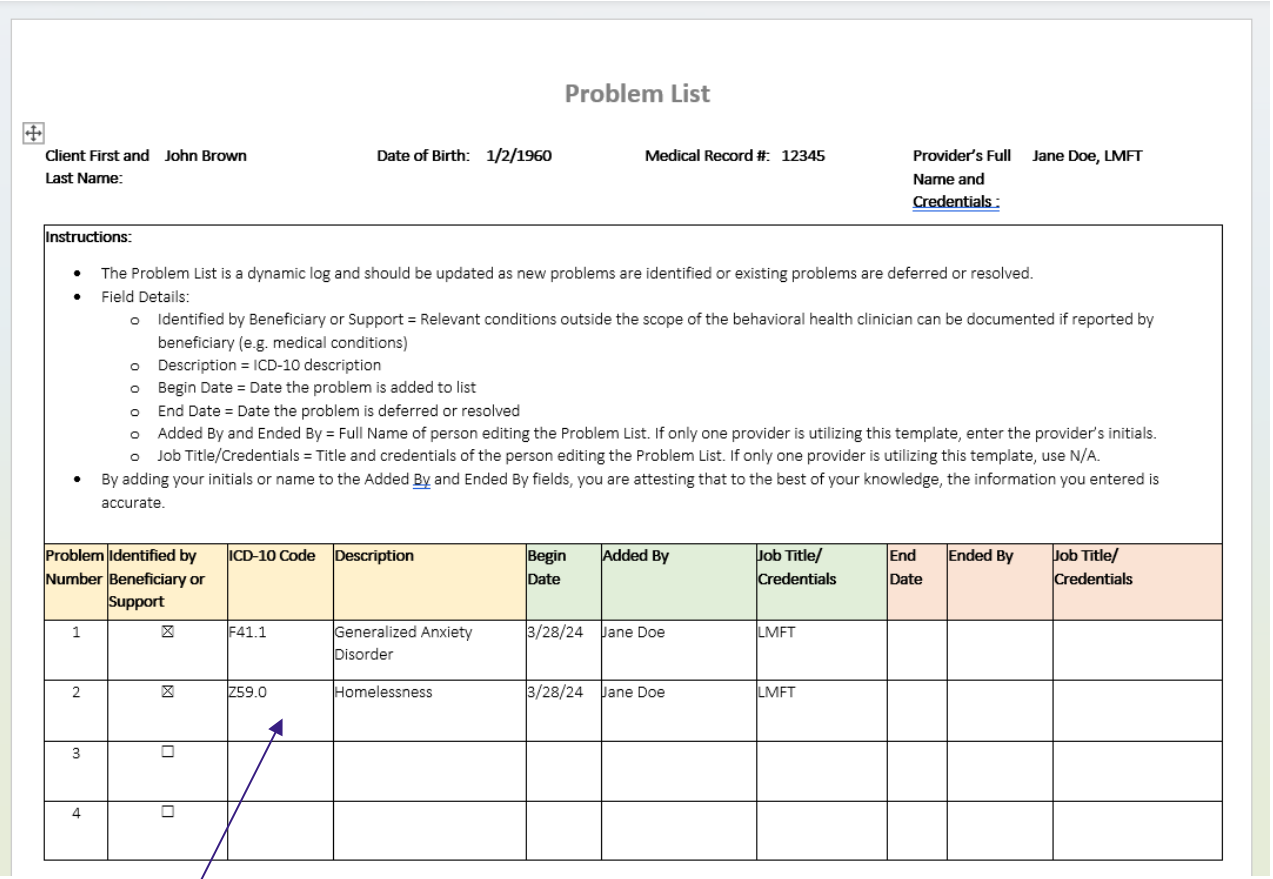
- The Problem List shall include, but is not limited to, the following:
  - Diagnoses/illnesses and/or problems identified by a provider **acting within their scope of practice**.
  - Diagnoses/illnesses and/or problems identified by the **member** and/or significant support person **may be added by all provider types**, noting where the information came from.
  - The name and title of the provider that identified, added, or resolved the problem
  - The date the problem was identified, added, or resolved.
- **Examples** include Major Depressive Disorder, Generalized Anxiety Disorder, Homelessness, Diabetes, etc.

Problem List Template

➢ACBHD has designed a Problem List template that includes prompts for all required information.

➢While not required, we **recommend** using this template or one that is similarly organized.

➢The Problem List Template is available in Word format on the ACBHD Provider Website and in the **county EHR: Clinician's Gateway.**



Problem List

Client First and Last Name: John Brown | Date of Birth: 1/2/1960 | Medical Record #: 12345 | Provider's Full Name and Credentials : Jane Doe, LMFT

Instructions:

- The Problem List is a dynamic log and should be updated as new problems are identified or existing problems are deferred or resolved.
- Field Details:
  - Identified by Beneficiary or Support = Relevant conditions outside the scope of the behavioral health clinician can be documented if reported by beneficiary (e.g. medical conditions)
  - Description = ICD-10 description
  - Begin Date = Date the problem is added to list
  - End Date = Date the problem is deferred or resolved
  - Added By and Ended By = Full Name of person editing the Problem List. If only one provider is utilizing this template, enter the provider's initials.
  - Job Title/Credentials = Title and credentials of the person editing the Problem List. If only one provider is utilizing this template, use N/A.
- By adding your initials or name to the Added By and Ended By fields, you are attesting that to the best of your knowledge, the information you entered is accurate.

Problem Number	Identified by Beneficiary or Support	ICD-10 Code	Description	Begin Date	Added By	Job Title/ Credentials	End Date	Ended By	Job Title/ Credentials
1	☒	F41.1	Generalized Anxiety Disorder	3/28/24	Jane Doe	LMFT			
2	☒	Z59.0	Homelessness	3/28/24	Jane Doe	LMFT			
3	☐								
4	☐								

Note that these are codified

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Knowledge Check: Problem Lists

A non-licensed staff member meets with the client and notices that the client is depressed. Should the staff member add depression to the Problem List?

- ❑ Yes
- ❑ No

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Knowledge Check- Answer

A non-licensed staff member meets with the client and notices that the client is depressed. Should the staff member add depression to the Problem List?

- ❑ Yes
- ✓ **No**

Review

- Diagnoses should be added/updated and/or resolved on the Problem List by providers **acting within their scope of practice**.
- Diagnoses identified by the **member** and/or significant support person **may be added by all provider types**, noting where the information came from.
- The **codified** diagnosis should be added to the Problem List by an LMHP (e.g. F32.9: Major Depressive Disorder)

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Progress Notes

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Progress Notes

- Progress Notes are an essential aspect of documentation that:
  - Track the evolution of treatment and a client's progress.
  - Document interventions, responses, and next steps.
  - Allow for communication about members' issues/needs amongst providers within a program.
- All service activities, including the development of Problem Lists and Assessments should be documented in a Progress Note.
- Exception: Providers using Clinician's Gateway (CG) do not need to create a Progress Note if an Assessment template is completed in CG.
- It is imperative that all engagement with members is documented in Progress Notes and kept in the clinical record.
- ACBHD has designed a Progress Note template that incudes prompts for all required information and it's available on the Provider Website and in the County EHR.
- While not required, we **recommend** using this template or one that is similarly organized.

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Progress Notes Best Practices and Required Timeframes

- Progress Notes should be clear and concise and easy to interpret when read independently.
- Progress Notes should be completed as soon as possible once a service concludes and within **three business days** for routine services or within **one business day** of a crisis service. **Note:** The date of service counts as day zero.
- There should be limited use of jargon, incorporation of the member's own words, and use of person-centered language.
- **Note:** Members own their clinical records and may request that a copy be sent to them or a third party.

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Progress Notes: Required Elements

The DHCS required elements of a progress note are:

- ❑ The type of service rendered.
- ❑ A narrative describing the service.
- ❑ The date the service was provided to the member.
- ❑ Duration of the service, including face to face time, travel, and documentation time.
- ❑ Location of the member at the time the service was rendered.
- ❑ A typed or legibly printed name, signature, and date of signature of the provider.
- ❑ Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
- ❑ The plan for next steps.

Progress Notes: Narratives

- The narrative will describe exactly what was done (e.g., met with the client to gather assessment information, taught mindfulness techniques, completed a TCM Care Plan and established goals, etc.), and assists the reader in understanding what the plan for continued care is.
- Progress Note narratives should be complete but concise.
- Progress Note narratives should be individualized and avoid recycled content or excessive copy/paste.
- Narrative information should match the service being claimed and have enough detail to clarify/justify the time spent providing the service.

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Progress Notes: Group Services

Core Progress Note requirements remain in place for group services with these additions:

- Progress Notes for group services should:
  - Describe the name and purpose of the group.
  - Identify the provider(s) that facilitated the group.
  - Include a brief description of the member's response to the service.

- For services involving multiple providers, one progress note is acceptable to submit claims for those involved but it must include: (a) total number of providers and their specific involvement in delivering the service, and (b) time involved in delivering the service for each provider.

- Each participant must have an individual Progress Note that documents the service encounter and their attendance in the group along with all other requirements.

Note: A list of all group participants must be maintained by the provider outside of the member's individual clinical record.

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Knowledge Check: Progress Notes

A Progress Note must be documented for <u>every</u> service that is billed to Medi-Cal and clearly reflect the services provided.

- ❑ True
- ❑ False

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Knowledge Check- Answer

A Progress Note must be documented for <u>every</u> service that is billed to Medi-Cal and clearly reflect the service provided.

- ✓ **True**
- ❑ False

Review

- Progress Notes should accurately describe the service provided and have enough detail to clarify/justify the time spent providing the service.
- Progress Notes should be individualized, with minimum/no copy/paste content.
- Progress Notes should include the following 2 narrative sections: 1) A description of the service, 2) The plan for next steps.

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Risk Assessments and Safety Plans

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Risk Assessments

- Licensed and non-licensed providers must have appropriate training in risk assessment and crisis intervention.
- **Crisis Intervention** is an unplanned, expedited service, required to stabilize an immediate crisis within a community or agency setting. A supervisor should be notified immediately if a crisis is suspected so the supervisor can help determine next steps and support the situation.
- **Risk assessment** involves reviewing the following for each member:
  - Behaviors that put the person at risk for danger to themselves or others, including suicidal ideation/planning/intent or homicidal ideation/planning/intent.
  - Personal and family history of suicidal or self-harm behavior
  - Aggression
  - Ability to care for self (e.g., grave disability issues)
  - Recklessness
  - Impulsivity
  - Context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse, etc.)
  - Resources and level of willingness to seek/obtain help

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Risk Assessment Resources

- **General information**: Suicide Prevention - National Institute of Mental Health (NIMH)
- **Suicide Risk Screening tools**: Ask Suicide-Screening Questions (ASQ) Toolkit - National Institute of Mental Health (NIMH)
- **Suicide Assessment Five Step Evaluation and Triage**: SAFE-T (Suicide Assessment Five-Step Evaluation and Triage) Flier

SAFE-T
SUICIDE ASSESSMENT

Five-Step
EVALUATION AND TRIAGE

1. **IDENTIFY RISK FACTORS**
   Note those that can be modified to reduce risk
2. **IDENTIFY PROTECTIVE FACTORS**
   Note those that can be enhanced
3. **CONDUCT SUICIDE INQUIRY**
   Suicidal thoughts, plans, behavior, method, and intent
4. **DETERMINE RISK LEVEL & INTERVENTION**
   Determine risk. Choose appropriate intervention to address and reduce risk.
5. **DOCUMENT**
   Assessment of risk, rationale, intervention, and follow-up

Suicide assessments should be conducted (1) at first contact; (2) with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; (3) prior to changes in behavioral health treatment; and (4) at inpatient discharge.

1. RISK FACTORS[1]

- Prior suicide attempt(s)
- Alcohol or substance use
- History of mental health concerns, particularly depression and other mood disorders
- Access to lethal means, including firearms
- Knowing someone who died by suicide, particularly a family member
- Social isolation
- Chronic disease and/or disability
- Lack of access to behavioral health care
- Prolonged feelings of hopelessness

POPULATIONS AT INCREASED RISK FOR SUICIDE

- American Indian, Alaska Native, and Tribal communities
- Black youth
- Rural communities
- LGBTQI + youth and young adults
- Middle-aged men
- Older adults

2. PROTECTIVE FACTORS[1]

Note: Protective factors, even if present, may not counteract significant acute risk

- Connectedness to people, family, community, and social supports
- Effective behavioral health care
- Life skills (including problem-solving skills, coping skills, emotional regulation, ability to adapt to change)

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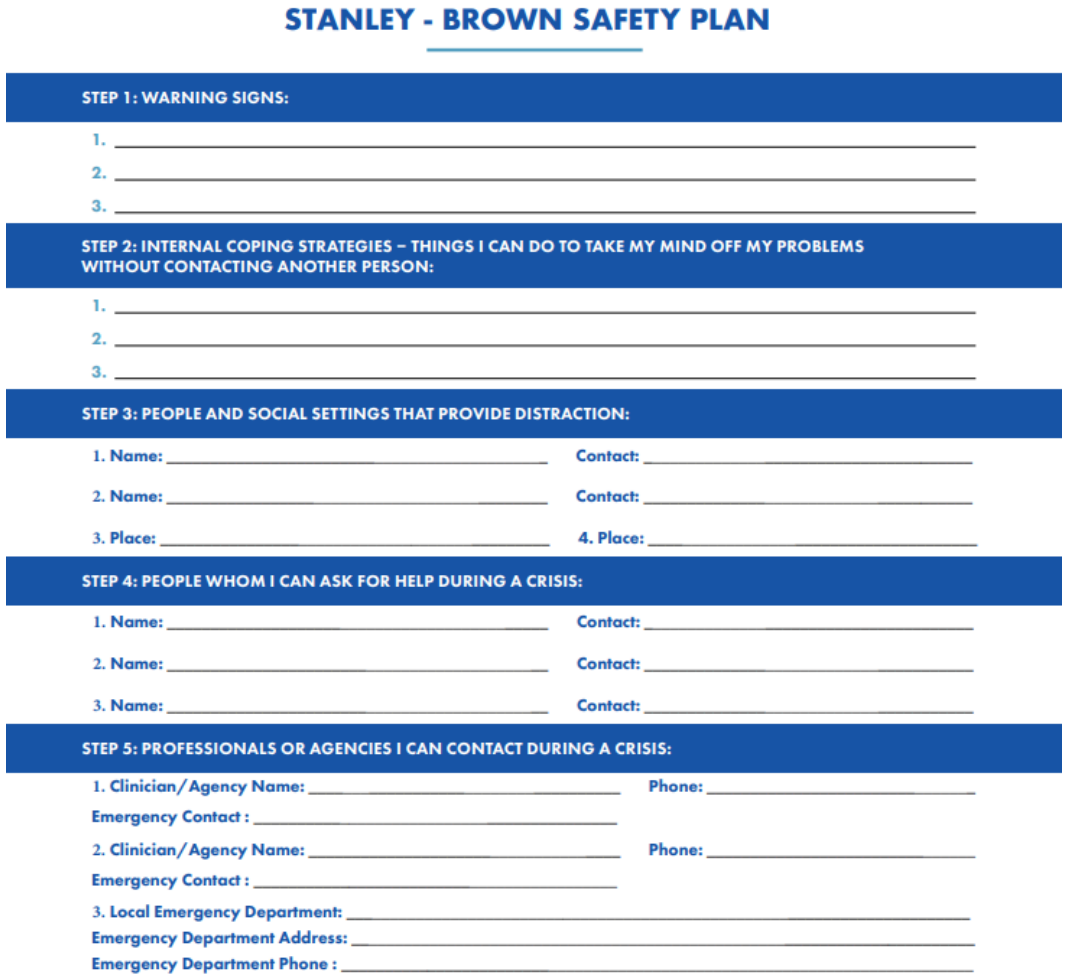
Safety Plan Details

- When risk is identified in a member's history, a Safety Plan must be created in partnership with the member and reviewed and updated periodically and as clinically appropriate.
- It is recommended that standardized templates be used for Safety Planning.
- The ACBHD Crisis System of Care utilizes the Stanley Brown Safety Plan which is available online in PDF form and is appropriate for all provider types to use.
- Regardless of format, Safety Plans should include a comprehensive overview of what to do when risk behaviors arise, including actions to take, resources, coping skills, and who to contact during a crisis.



STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ 4. Place: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____

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Safety Plan Details

- Examples of information that should be captured in a Safety Plan include:
  - **Warning signs** that the client is decompensating from a safety perspective (e.g., experiencing a manic episode, thoughts of self-harm, excessive substance use, isolation, etc.)
  - **Coping strategies** that the member use to help stabilize mood and thoughts (e.g., calling a friend, mindfulness practices, exercise, attending a therapy session, etc.).
  - **Resources** that can be utilized for help (e.g., parents, neighbors, mental health agencies, crisis hotlines, online support groups, etc.).
- Safety Plans should be well-organized and easy to reference for members when they're in crisis.

Note: High-risk factors should be reviewed frequently with subsequent updates to Safety Plans as needed.

Knowledge Check: Safety Plans

Risk assessments and Safety Plans can only be completed by licensed mental health professionals.

- ❑ True
- ❑ False

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Knowledge Check- Answer

Risk assessments and Safety Plans can only be completed by licensed mental health professionals.

- ❑ True
- ✓ **False**

Review

- Risk Assessments and Safety Plans may be completed by licensed professionals as well as unlicensed staff who have sufficient training to do so.
- A supervisor should be notified immediately if a crisis is suspected to assist with next steps and support the situation.
- Safety Plans should be created in partnership with the member and reviewed and updated periodically and as clinically appropriate.

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Plan Development

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Plan Development

- Plan Development involves creating an individualized care/treatment plan, monitoring progress toward plan goals, applying plan revisions and additions, as necessary.
- It is a collaborative process that includes the guidance and organizational skills of the provider and the input and direction of the member.
- Care plans may be documented in a Progress Note or a specific Plan Template.
- If documenting the care plan in a Progress Note, it is recommended that providers use language or labels to make them easily identifiable (e.g., TCM Care Plan, goals, action steps, transition plan, etc.)
- Although care plans are recommended for all service types, State and/or Federal regulations **require** them for certain treatment services, including Targeted Case Management and Certified Peer Support Services.*

* For more services that require care plans, See BHIN 26-068 Appendix for more information

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Plan Development: Targeted Case Management (TCM)

- Targeted Case Management (TCM) services assist members in gaining access to needed medical, social, educational and other services.
- They include making targeted and individualized referrals for services and coordination of services and supports.
- TCM Care Plans are required and can be embedded in a Progress Note or be a stand-alone document.
- TCM Care Plans must include **all** the following:
  - Specify the goals and actions to address the medical, social, educational and other services needed by the member.
  - Include activities such as ensuring the active participation of the member and working with the member and others to develop those goals.
  - Identify a course of action to respond to the assessed needs of the member.
  - Identify a transition plan when the member has achieved the goals of the care plan.

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Plan Development: Certified Peer Support Services

- Peer Support Services rendered by **Certified Peer Support Specialists** must be recommended by a physician or LMHP and documented in a **Care Plan** prior to being provided.
- The Care Plan will include similar elements to the TCM Care Plan and should be documented within a Progress Note with approval clearly indicated.
- Peer support services provided by non-certified peers, using the provider type *Other Qualified Providers*, do not require a Care Plan.

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Care Plan Example Within a Progress Note

Writer met with client today who reported he would like to get in better shape. Discussed options for adding more physical activity to his day, including walking or online exercise videos.

Discussed/agreed to the following goals:

1) Client will check online and identify what types of exercise programs appeal to him (e.g. martial arts, yoga, tai chi, etc.).
2) Client will identify a video of no more than 30 minutes to try out at least one time during the next week.
3) Client will let the writer know how it went during our next session.
4) Once we agree on an exercise routine, client will review and get sign-off from his physician.

Knowledge Check: Care Plans

Care Plans are only required for Targeted Case Management Services.

- ❑ True
- ❑ False

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Knowledge Check- Answer

Care Plans are only required for Targeted Case Management Services.

- ❑ True
- ✓ **False**

Review

- Care Plans are required by State and Federal regulations for specific services, including Targeted Case Management and Certified Peer Support Services.
- Although Care Plans are not required by the regulations for all services, providers are encouraged to establish plans of care in collaboration with members to allow for focused goals and interventions.

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Resources and Next Steps

Resources

- CalMHSA Clinical Documentation Guide
- Documentation Best Practices training. **Highly Recommended.** Includes basics of documentation best practices and the concept of collaborative documentation.
- ACBHD Provider Website
- Quality Assurance Webpage
- Scope of Practice Grid
- BHIN 23-068

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Questions and Next Steps

- We are here to help!
- Please email questions to QATA@acgov.org
- Please attend the next training session in this series:

Documentation Training -Part 2 Q&A

April 2, 2026, 11:00 AM-12:00 PM

Thank you for attending.

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