

PROGRESS NOTES

NOTE: Training for the Client Plans and Progress Notes in the EHR began in October 2011. Training will continue throughout the calendar year 2012. Programs not yet trained to use the EHR to document Client Plans and Progress Notes will continue to use paper during the transition and will be held to the same documentation timelines and standards as outlined in the following descriptions unless noted otherwise.

PROGRESS NOTES

2014

- WHEN:** As needed to document client care at every service contact where a progress notes entry is required.
- ON WHOM:** All clients with open cases receiving services.
- COMPLETED BY:** Staff delivering services within scope of practice. Co-signatures must be completed within timelines.
Note: When more than one staff member provides services, one staff member may write the progress note for all staff; but the unique role/function/contribution of each staff member participating must be documented.
- MODE OF COMPLETION:** Data must be entered into the Electronic Health Record.
- REQUIRED ELEMENTS:** Content of each progress note must support the service claimed. When using a template all prompts must be addressed.
- BILLING:** After rendering a service, a progress note is to be completed. Service entry shall be completed as a part of the progress noting process. Completion and final approval of the service and the progress note by the staff is a certification that the documented services were provided personally and that the services were medically necessary. **Notes not completed within 14 calendar days (Service Date is Day 1) must be billed with nonbillable service codes, and are subject to recoupment if claimed.**
- NOTE:** Every progress note within the EHR must be completed and final approved within 14 calendar days (service date is Day 1). When it is not completed and final approved, the note is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Progress notes are not viewed as complete until they are final approved.
- Paper progress notes are completed only when staff have not yet been trained in the EHR, or if the system is down. In these cases, services will be entered manually into the EHR. Paper progress notes will be completed by Day Rehab staff, and Medical staff who do not enter into the EHR.

Client:		Client #:		Program:	
Date of Service:		Unit:		SubUnit:	
Server ID:		Service Time:		Travel Time:	
Person Contacted:		Place:		Appointment Type:	
Overview of Group:(Describe the focus of the group and the intended outcome – a global description of the group, not individualized for each client. Justify need for Collateral Server)		Outside Facility:		Contact Type:	
Collateral Server ID:		Service Time:		Documentation Time:	
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GROUP PROGRESS NOTE					
CLIENT AFFECT/MOOD:					
CLIENT APPEARANCE:					
LEVEL OF ORIENTATION (person, place, time, day, month, year, current situation):					
PRECIPITATORS/RECENT STRESSORS: :					
SAFETY ISSUES: (include client's complaints/symptoms/focus of group/interventions):					
PARTICIPATION IN GROUP (complaints/symptoms/interventions):					
PROGRESS TOWARDS GOALS/OBJECTIVES:					
PLAN:					
_____ Signature/Title/Credential		_____ Date		Printed Name/Credential/Server ID#	
_____ Co-Signature/Title/Credential		_____ Date		Printed Name/Credential/Server ID#	

County of San Diego
Health and Human Services Agency
Mental Health Services

GROUP PROGRESS NOTE
HHS:MHS-684 (11-14-08)

Client:

Case #:

Program:

