

5122-27-06 Progress Notes
Intent & Explanation

5122-27-06 **Progress notes.**

(A) The agency shall document progress or lack of progress toward the achievement of specified treatment outcomes identified on the individualized service plan (ISP). Documentation of progress may be done through use of checklists and/or brief narrative.

Intent and explanation: The rule offers the provider the flexibility to use either checklists or brief narrative, or a combination of both, to document the provision of services. There may be sessions when using checklists is appropriate. In other sessions, the staff providing the service may realize a need to use narrative (on its own or in addition to a checklist) to document the service provision. Some clinicians may feel more comfortable always using narrative, e.g. when providing counseling. The decision is based on agency protocol and individual clinician judgment.

(B) Each individual staff providing services shall document progress or lack of progress each day that a service is provided.

Intent and explanation: Each staff person who provides a certified mental health service must complete a progress note to document the provision of the service each day that one or more services is provided.

The exception shall be the provision of group services, when a minimum of one staff person shall complete the progress note documentation.

Intent and explanation: When more than one staff person provides group services, agency protocol and individual clinician judgment can determine whether one staff will author and sign a progress note for a client receiving group mental health services, one staff will author and each staff provider will sign the client's progress note, or all staff providing the service will co-author and co-sign the progress note. Individuals providing service should also reference requirements of state or national licensing/credentialing boards when determining whether to author and/or sign a group progress note.

Paragraph (A) states that the documentation of progress must be based on an ISP, so staff must write an individualized progress note for each client receiving services, rather than write the same progress note for each member of the group.

(1) When multiple contacts of the same type of service are provided in one day, the staff may complete one progress note per day, rather than per service contact.

Intent and explanation: An individual staff person who provides more than one session/service contact of the same type of certified service in a calendar day may write one progress note to cover all service contacts provided that day.

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However, there is no requirement that multiple contacts provided in a single day must be combined into a single progress note. Instead, the rule offers an individual staff who provides multiple contacts of the same type of service in one calendar day the flexibility to either author one progress note to cover all service contacts, or to author a separate progress note for each service contact in the calendar day. An individual provider may utilize both methods throughout the course of treatment for a client. The decision is based on agency protocol and individual clinician judgment.

If more than one staff person provides the same type of service in a calendar day, e.g. two different staff persons provide Community Psychiatric Supportive Treatment (CPST) service at differing times (not group CPST) to the same client on the same day, then each staff person must author his/her own progress note.

(2) When the same staff person provides more than one type of service in the same day to an individual client, e.g. behavioral health counseling and therapy service and community psychiatric supportive treatment service, the staff shall complete a separate progress note for each different type of service provided.

Intent and explanation: If the same staff person provides more than one type of certified service in the same calendar day, e.g. one staff person provides a session of both Behavioral Health Counseling & Therapy service and CPST service to the same client in a calendar day, then the staff person must author two separate progress notes, one for each service.

(C) Documentation shall include, at a minimum:

(1) The date of the service contact;

Intent and explanation: The date must include the month, day and year.

(2) The time of day and duration of each service contact;

Intent and explanation: The start time of each separate service contact must always be documented. A provider may document duration by either including the stop time, or listing the duration (length) of the session. Start and stop times must include “AM” or “PM”. Duration must include whether the time is measured in minutes, hours, or both. Examples include:

- “Start Time: 1:00 PM Stop Time: 1:30 PM”
- “Start Time: 2:30 PM Duration: 75 minutes (or 1 hour & 15 minutes)”

Time of day and duration must be documented for each service contact, even when documenting multiple service contacts in a calendar day on a daily progress note. If a staff is using a daily progress note to document multiple contacts of the same type of service in a calendar day, then time of day and duration must be included for each service contact. It is not permissible to

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combine the service times for all contacts in a single day as one start time and then a duration which includes all of the service contact time added together.

(3) The location of each service contact;

Intent and explanation: An agency should determine the protocol for documenting the location (agency office, client home, inpatient hospital, etc.) where each service was provided. This protocol should include whether to utilize standardized agency abbreviations to represent various locations, rather than hand-writing the location on each progress note. Although technically not required, an agency using abbreviations should ensure that all staff utilize the same abbreviations. If not, a form documenting the abbreviations a particular staff provider utilizes needs to be placed in each individual client's record. An agency can choose its own abbreviations to document location, however, an agency may prefer to utilize the Multi-Agency Community Services Information System (MACSIS) "place of service" billing codes, which are federally defined. This may be most helpful if agency protocol includes that the progress note form itself contains the billing strip.

Location must be documented for each service contact, even when documenting multiple service contacts in a calendar day on a daily progress note. If an individual staff person uses a daily progress note to document multiple contacts of the same type of service in a calendar day, then location of service must be included for each service contact. The provider needs to link the location data element to the time of day and duration of the service contact that is described in paragraph (B)(2) of this progress note rule.

(4) A description of the service(s) rendered;

Intent and explanation: The individual provider needs to utilize checklists and/or narrative to document the service activities/interventions provided. Please also reference the intent and explanation for paragraph (A) of this rule.

(5) Whether or not the intervention provided is specifically authorized by the service plan that was developed based on a Mental Health Assessment. The exception shall be the following circumstances, in which case the documentation must include the presenting problem in addition to the other requirements of this rule:

(a) Pharmacologic management service provided as the least restrictive alternative prior to completion of a Mental Health Assessment, as described in paragraph (B) of rule 5122-29-04 of the Administrative Code, and

(b) Crisis intervention mental health service when not listed on the treatment plan;

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Intent and explanation: The individual provider must attest that he/she provided the service in accordance with the individualized service plan, which by rule, is based on a mental health assessment. When utilizing checklists or a brief narrative to describe the service activity, this can be documented by use of a “Yes” or “No” response to this statement as a data element on the progress note form. For example, a line on the progress note form utilized by the agency may read “Is service provided authorized by the ISP which was developed based on a mental health assessment? Answer: Yes/No.” An agency may prefer, but is not required to do so, to utilize a prompt statement including the term “medically necessary”. In this case, another example is that a line on the progress note form utilized by the agency might read “Is service provided medically necessary as authorized by the ISP which was developed based on a mental health assessment? Answer: Yes/No”. A third example might be when a staff utilizes narrative to describe the service in order to meet the requirement of paragraph (C)(4) of this rule. In this scenario, a staff can meet the requirement to demonstrate whether the service intervention is authorized by the ISP with a properly written narrative or, i.e. one that clearly describes interventions that support the delivery of services in accordance with an ISP developed based on the mental health assessment. If documenting service provision with narrative, the staff may still choose to utilize a “Yes” or “No” response to a prompt question (see the two examples earlier in this paragraph), but is not required to do so. A fourth example is, if an agency has a medical record system which can generate individualized checklists that are based on each client’s ISP, then the use of client specific checklists to describe the service interventions in paragraph (C)(4) of this rule may also meet the requirements of this rule. This is most likely to be true only if the checklist options are not the same for each agency client. Again, the staff may still choose to utilize a “Yes” or “No” response to a prompt question, but is not required to do so. As noted in the explanation for paragraphs (A) and (C)(4) of this rule, agency protocol and individual clinician judgment will determine whether a provider documents the service provision utilizing checklists, narrative or a combination of both, either during an individual session or over multiple sessions. Following this, an agency and/or individual clinician have the same flexibility to choose whether to utilize a “Yes/No Prompt Question” (including the content of the prompt question), a narrative service description, client specific checklists, or a combination to demonstrate compliance with paragraph (C)(5) of the rule.

According to paragraph (B) of rule 5122-29-04, Mental Health Assessment service, of the Ohio Administrative Code (OAC), a mental health assessment must be completed prior to the initiation of any mental health service, then goes on to state two exceptions, which are providing Crisis Intervention Mental Health service or Pharmacologic Management service as the least restrictive alternative in an emergency situation. A staff delivering Pharmacologic Management service under this scenario will not have a mental health assessment or ISP to which he/she may refer. When delivering Crisis Intervention Mental Health service, even if the person receiving the service is an

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active agency client and has a completed mental health assessment, the staff person must provide interventions to address the crisis. When delivering either of these services as described in this paragraph, good clinical practice dictates that the presenting problem must be documented in addition to other information that is required by the service standards, along with any other information that the staff person feels is clinically necessary to document. This information, if properly documented, will support meeting the requirements of paragraph (B)(5)(a) or (B)(5)(b) of this progress note rule. The specific standards for both Crisis Intervention Mental Health service and Pharmacologic Management service are located in chapter 5122-29 of the Ohio Administrative Code.

(6) The assessment of the client's progress or lack of progress, and a brief description of progress made, if any;

Intent and explanation: The individual provider must determine whether or not the client is making progress, and document such on the progress note. This may be accomplished through the use of a checkbox option on a progress note form, offering “no progress made” or “progress made”. If a client has made progress, the staff providing services needs to include, either through brief narrative or more detailed checklists, information explaining the progress made, as it relates to specified objectives on the individualized treatment plan. Including a brief description when there is a change, gives a clearer picture of a client’s progress in achieving the treatment plan outcomes on the ISP, and will help when conducting any ISP review and revision. Documenting this information also promotes continuity of care, i.e. that a new treatment provider can read the record and know what progress has been made, if any.

(7) Significant changes or events in the life of the client, if applicable;

Intent and explanation: The clinical record should tell a story, starting with the initial mental health assessment, continuing through the documentation of service provision, and then termination of service when that time arrives. The majority of information is contained in progress notes. It is important that the clinical record contain the necessary information to allow for continuity of care, i.e. that a new treatment provider can read the record and know what has occurred in the course of treatment, and significant events in the client’s life. Significant changes are those which may impact the course of or be a focus of treatment over time. Therefore, determining which changes/events are “significant” and thus must be documented is individualized to a client, i.e. an event/change which is significant in the life of one client may not be significant in the life of another client. Agency protocol, individual clinician judgment, and common sense based on continuity of care needs will guide determining when information must be documented.

“As applicable” means the provider need only document this information when it is obtained. The individual staff providing the service is not required to

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document anything if there is no known significant change or event in the client's life.

(8) Recommendation for modifications to the ISP, if applicable; and

Intent and explanation: An individual providing service needs to document if he/she believes the ISP needs to be revised and then explain why. This is a recommendation, thus documenting this information does not require that the treatment plan then be modified. Instead, it means that either an internal clinical staffing and/or a review of the ISP must occur to determine whether or not an ISP revision is warranted. The client must be included in an ISP review. There are several factors which may guide the next steps after a staff person makes a recommendation to modify the ISP, including agency protocol, whether or not the client receives any other service(s) from the agency, and the credentials of the individual staff making the recommendation. For example, if a client is receiving only Behavioral Health Counseling & Therapy service, the clinician is independently licensed, and the revision is still reflective of the most recent mental health assessment, the clinician might engage the client in a therapeutic discussion regarding the ISP, and make a revision in accordance with rule 5122-27-05 of the Ohio Administrative Code. In another example, significant changes in client functioning may indicate the need to complete an update to the mental health assessment prior to revising the ISP.

“As applicable” means the provider needs only document this information if recommending a modification to the ISP. The service provider is not required to document anything if not recommending modifications to the ISP.

(9) The signature and credentials, or initials, of the provider of the service and the date of the signature. The credentials are the provider's qualifications to provide the service according to the matrix in Chapter 5122-29 of the Administrative Code. A provider signing a progress note utilizing initials must maintain a signature sheet, including credentials, in the individual client record (ICR).

Intent and explanation: Each person authoring a progress note must sign the note, and include the date of the signature, in addition to the date the service was provided. Rule 5122-29-30 of the Ohio Administrative Code includes a service matrix, which lists the required credentials of those who are qualified to provide and supervise certified services. This matrix also lists the accepted credentialed abbreviation. A staff person signing his/her name must either include the listed abbreviation, e.g. Jane/John Doe, QMHS, or spell out the credential in its entirety, e.g. Jane/John Doe, Qualified Mental Health Specialist.

The rule does offer each staff person utilizing paper progress notes the option to sign each note with his/her initials. If electing this option, the staff person must place a signature sheet in the ICR. The signature sheet must include the staff's

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name, credentials and initials. A copy of this signature sheet must be present in the ICR of each client to which the staff person provides services.

An individual utilizing electronic records must include a signature or initials in compliance with rule 5122-27-09 of the Ohio Administrative Code and section 3701.75 of the Ohio Revised Code. The agency policies and procedures for electronic signatures must address the need to include credentials.

(D) Documentation in the progress note, or elsewhere in the individual client record, may include a notation that there is no change in the client's risk of harm to self or others, or, if there is a change, the results of a review of the client's ideation, intent, plan, access, and previous attempts.

Intent and explanation: “May” denotes that an agency has the flexibility to determine whether or not to include this information in a progress note or elsewhere in the clinical record. There is no requirement to do so, however, it is good clinical practice. In some situations, agency protocol may dictate that certain staff, after noticing a change in the client’s risk of harm to self or others, must bring in another provider (internal or external) to complete the gathering of the information and/or to assess the action that must be taken based on the information gathered. This is often based on the individual staff person’s competencies. If applicable, an agency must always adhere to the provisions of section 2305.51 of the Ohio Revised Code, which is frequently referred to as “duty to warn” or “duty to protect”.