In Home Therapy Progress Note

Use this note to document In Home Therapy as defined by MassHealth Managed Care Entities' performance specifications and the person's response to the intervention during a specific contact.

Data Field	
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth.
Organization Name	Record the name of the organization.
Data Field	**Therapeutic Interventions Provided / Units**
Therapeutic Intervention Provided/Units	Record the therapeutic intervention(s) provided – check all that apply. If "other" is selected, indicate what the intervention was. Next to each type of intervention, indicate the number of units provided. As of June, 2009, payers (MHP, NHP, NH, Fallon and BMC) have defined one unit as 15 minutes. Note: Intensive Family Therapy can only be provided by a master's level clinician. **Example:** ☑ Intensive Family Therapy 4 Units ☑ Member Transportation 2 units
Describe the Intervention Provided	Describe the specific intervention used. **Example:** Provided 1 hour (4 units) of Intensive Family Therapy using Solution Focused therapy and drove the person to a doctor's appointment. Asked the "miracle question" and did scaling.
Person's Report of Progress Towards/ Goals/Objectives Since Last Session.	Document person's self-report of progress towards goals since last session including other sources of information, such as family, case manager, etc.. **Example**: Person reports some progress in anger control – only one argument with parent and two with teachers this week. Parents concurred.
Data Field	**New Issues Presented Today**
New Issue(s) Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. **Example:** Person described being involved in an argument at school today. Person was not hurt but expressed concern about consequences at school and home. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA

	Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same Date and write a detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form. **Example:** Person reported for the first time that she was a victim of abuse/neglect at the age of twelve as recorded on the Comprehensive Assessment Update of this date.
Data Field	**Person's Condition**
Person's Condition: **Mood/affect** **Thought Process/Orientation** **Behavior Functioning** **Medical Condition** **Substance Use**	This is a mini-mental status exam. Check appropriate box to indicate person's condition or to indicate *No Change*. Also, describe any changes. **Note**: Notable is defined as behavior or symptoms different from the person's baseline status. These changes may be signs the person is experiencing increased problems or distress or may indicate an improvement in functioning/symptoms/behavior. Note: This section should be completed by Master level clinicians. **Example:** Thought process/orientation is marked *Notable* and the comments are: "John is distracted and responding to voices he is hearing today." However, if John's baseline is that he always hear some voices and responds, a *Notable* comment would not be needed unless the intensity or impact of the voices on John is significantly different than his baseline.
Data Field	**Risk Assessment**
Risk Assessment	Check appropriate box(es) to indicate area(s) and type(s) of risk or check *None*. Describe types of risky behavior such as cutting, mutilation, unsafe sex etc. under Additional Comments. If any box except *None* is marked, be sure to document in the *Therapeutic Interventions Delivered in Session* section how this was addressed and resolved. Note: This section should be completed by Master level clinicians.
Data Field	**Goal(s) Addressed as Per Individualized Action Plan**
Goal(s) as Addressed Per Individualized Action Plan, Behavioral Action Plan, Other plan	Identify the plan used as the source of the goals and objectives. Identify the specific goal(s) and objectives in the Individualized Action Plan being addressed during this intervention. All interventions must be documented in a progress note and must be targeted towards specific goal(s)/objective(s) in the Individualized Action Plan except as noted above under new issues.
Functioning (Observed or reported)	Document, as appropriate, person's functioning in one or more of the areas listed below. The information can be as reported by person or by others who have observed or interacted with person. Reporting on the person's functioning provides important data that can either positively or negatively impact the person's response to the interventions in this session, as well as the person's overall progress toward his/her goals/objectives. 1. General ability of person to function in community since last visit. **Example**: Person continues to live with mother with no reported outbursts or crisis interventions needed. Person reports he is sleeping better.

	2. Functioning of person in area of focus for today's interaction. **Example:** Person continues to struggle with having enough concentration to balance do his homework 3. Observed functioning of person in session that would impact his/her ability to participate in session or to benefit from the session. **Example:** Person is unable to work further on anger control today because of lack of sleep and concentration.
Person's Response to Intervention/ Progress Toward Goals and Objectives	This section should address **BOTH**: • *The person's response to the intervention* - Include evidence the person participated in the session and how, and information about how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • *Progress towards goals and objectives* - Include an assessment of how the session has moved the person closer, further away, or had no discernable impact on meeting the session's identified goal(s) and objective(s). **OR** • *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to produce positive change in the person. **Example:** Person was able to learn the relaxation technique and stated he thought it made him calmer. He was not convinced that he would be able to do the technique without worker present. Person was able to create a list of ways to remind himself to use the technique. Person made progress toward goal of being calmer and not getting into fights.
Data Field	**Additional Information/Plan**
Plan Additional Information	The staff should document future steps or actions planned with the person such as homework, plans for the next session, etc. Document additional pertinent information that is not appropriate to document elsewhere. **Example:** Person will keep a mood journal to identify triggers to explosive episodes and bring to next session to review and discuss alternative responses.
Data Field	**Signature Instructions**
Provider Name	**Legibly** print the provider's name and credentials.
Provider Signature/ Credentials	**Legibly record provider's** signature and date.
Supervisor Name	If required, **legibly** print name of supervisor.
Supervisor Signature/Credentials	If required, **legibly record supervisor's** signature, credentials and date.
Next Appointment	Indicate the date and time of the next scheduled appointment.

Instructions to complete the Billing Strip:

Data Field	Billing Strip Completion Instructions
Date of Service	Date of session/service provided
Provider Number	Specify the individual staff member's "provider number" as defined by the individual agency.
Location Code	Identify Location Code of the service. Providers should refer to their agency's billing policies and procedures for determining which codes to use.

Procedure Code	Identify the procedure code that identifies the service provided and documented. Providers should refer to their agency's billing policies and procedures for determining which codes to use.
Modifier 1, 2, 3 and 4	Identify the appropriate modifier code to be used in each of the positions. Providers should refer to their agency's billing policies and procedures for determining which codes to use for Modifiers 1, 2 3 and/or 4.
Total BA Units	Indicate the total number of 15 minute units provided by the BA level staff person.
Total MA Units	Indicate the total number of 15 minute units provided by the MA level staff person.
Diagnostic Code	Use the numeric code for the primary diagnosis that is the focus of this session. Providers should use either ICD-9 or DSM code as determined by their agency's billing policies and procedures.