# Mobile Crisis Documentation

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# Overview

- Requirements for Billing
- Problem List/Billing Diagnosis
- Procedure Codes
- Content of Service Note
- Location of Services
- Respectful Language/Cultural Considerations

- Other Required  Documentation Trainings:
  - CalAIM
    - Overview Module
    - Progress Notes Module
    - Problem List/Diagnosis Module
  - Dispatch Screening, Assessment & Safety Plan Tool Training
  - M-TAC
    - Medi-Cal Mobile Crisis TA Center (M-Tac) (camobilecrisis.org)

# Requirements for Billing

## Documentation:

- Dispatch Tool
- Crisis Assessment
- Crisis Safety Plan (if clinically indicated)
- Encounter Service Note
- Crisis Follow Up Note

## Staffing

- 2 MH Staff: At least 2 providers must be available for the duration of the initial mobile crisis response.
  - 1 of the 2 required members could participate via telehealth for the duration of the mobile response.
- The Mobile Crisis team providing the initial response must include or have access to an LPHA, either in person or via telehealth.

# Problem List

- There is a requirement to document problems encountered during the mobile crisis service (i.e., what is being addressed during the crisis?)
- The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters
- The problem list can include, but is not limited to, the following:
  - Current DSM Diagnoses identified by a provider acting within their scope of practice, if any
  - Problems identified by a provider acting within their scope of practice
  - Problems or illnesses identified by the client and/or significant support person
  - The name and title of the provider that identified and added the problem, and the date the problem was identified and added

# Who creates or edits the problem list?

- Any staff providing services as a part of the mobile crisis encounter is responsible for the client's care should create and maintain a problem list
- Providers must work within their scope of practice in identifying and adding problems:
  - MHRS, "other qualified providers," AODS counselor, including Peer Specialists, can add problems like "lack of housing" or other psychosocial conditions
  - DSM-5 diagnoses can only be added or removed by clinicians or MDs
  - Other physical health conditions should only be added by MDs or RNs working within the scope/expertise
- Document any problems identified during the encounter on the Problem List.

# Problem List Example

## PROBLEM LIST EXAMPLE

A problem list which codifies a person's needs showing the entire care team the focus of services

| Code | Description | Begin Date | End Date | Identified by | Job Title |
|---|---|---|---|---|---|
| F33.3 | Major Depressive Disorder recurrent, severe with psychotic symptoms | 01/19/2022 | Current | Name | Psychiatrist |
| F10.99 | Alcohol Use Disorder, unspecified | 01/19/2022 | Current | Name | Licensed Clinical Social Worker |
| I10 | Hypertension | 02/25/2022 | Current | Name | Primary Care Physician |
| Z62.819 | Personal history of unspecified abuse in childhood | 04/16/2022 | Current | Name | Licensed Clinical Social Worker |
| Z59.02 | Unsheltered homelessness | 05/01/2022 | Current | Name | Peer Support Specialist |
| Z59.41 | Food insecurity | 05/01/2022 | Current | Name | Peer Support Specialist |

# Billing Diagnosis

With the implementation of CalAIM, a client doesn't require a mental health disorder diagnosis to receive medically necessary SMHS, especially during the assessment phase of treatment, however ICD diagnostic codes are required in the system for claiming and reimbursement services.

Z codes meet the federal requirement for claims and do not indicate a diagnosis of a mental health disorder or a substance use disorder.

If a DSM Diagnosis has yet to be established, staff are encouraged to use a Z Code (social determinants of health) from list started on page 31.

# Procedure Codes

## Mobile Crisis Encounter H2011

- Used when the Mobile Crisis Team is dispatched to a site to address a person's crisis. This is a bundled service that includes all required crisis service components. Staff should continue to track the time spent on each encounter.

## Mobile Crisis Follow Up (non-billable)

- Follow up (or attempted follow up) with the client within 72 hours of the initial mobile crisis response. This will include the continued resolution of the crisis, as appropriate, and may include updates to the crisis plan, or additional referrals to ongoing

## Add On Codes—

- **Transportation Mileage A0140**
  - Mileage reimbursement if driving the client to an alternate setting (i.e. emergency department) during mobile crisis encounter.
- **Transportation Staff Time T2007**
  - Time spent stabilizing client during transport or assists client by waiting with them for the next level of care (i.e. waiting in emergency waiting room with client) during mobile crisis encounter.

# Service Note Requirements – Overview

- The type of service rendered (the procedure code)
- A narrative describing the service, to include:
  - How the service addressed the client's behavioral health need (e.g., **symptom, condition, diagnosis, and/or risk factors**)
  - The interventions you provided
  - The response to those interventions
- The date that the service was provided to the client
- Duration of the service, separating documentation time from direct service time
- Location of the service (e.g., "Office," "Phone," "Telehealth")
- A typed or legibly printed name, signature of the service provider, (w/ professional degree/licensure) and date of signature (electronic signatures accepted)
- Next steps including, but not limited to, planned action steps by the provider or by the client, collaboration with the client, collaboration with other provider(s) and any update to the problem list as appropriate

# Mobile Crisis Encounter Notes

- Content of the service:
  - Mobile crisis response interventions (including crisis assessment completed) provided by the mobile crisis team – how these addressed the client's behavioral health need.
  - Referrals/Linkage to ongoing supports (when appropriate)
  - Facilitation of warm handoffs to higher levels of care, to include how transportation happened (when appropriate)
  - If not doing the crisis/safety plan = must document why in service note
- Plan – Next Steps:
  - Planned action steps by the provider or client, collaboration with other providers, and any update to the problem list as appropriate

How to Complete the Mobile Crisis Service Note - 2023 CalMHSA

# Mobile Crisis Encounter Note: *Mobile Crisis Response*

- The mobile crisis response may include:
  - Crisis assessment to evaluate the current status of the client experiencing the behavioral health crisis with the goal of mitigating any immediate risk of danger to self or others, determining a short-term strategy for restoring stability, and identifying follow-up care, as appropriate.
  - Trauma-informed on-site intervention for immediate de-escalation of behavioral health crises;
  - Skill development, psychosocial education and initial identification of resources needed to stabilize the client;
  - Immediate coordination with other providers involved in the client's care;
  - Immediate coordination with other crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, CSU, general acute care hospitals, emergency departments, crisis residential treatment programs); and
  - Provision of harm reduction interventions, including the administration of naloxone to reverse an opioid overdose, as needed.

# Example of actual note

**Client:** Perkins, Sage
**ID #:** 2000877
**Age:** 37

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

## Mobile Crisis Progress Note

**Date of Service: 03/29/2024**

**SonomaCntySmartcareQA | 12-26-2023**

**Mobile Crisis Progress Note**

| | | | | | |
|---|---|---|---|---|---|
| **Client Name:** | Sage Perkins | **Client ID:** | 2000877 | **Status:** | Show |
| **Clinician Name:** | Marcia Williams | **Service:** | Mobile Crisis Encounter | | |
| **Date Of Service:** | 03/29/2024 | **Start Time:** | 11:58 AM | **Face to Face Time:** | 62.00 Minutes |
| **Program:** | Mobile Crisis Test Program | | | | |
| **Location:** | Mobile Unit | | | | |
| **Travel Time:** | 26 Minutes | | | | |
| **Documentation Time:** | 8 Minutes | | | | |

### Mobile Crisis Team

| | |
|---|---|
| **Provider 2:** | Sanchez, Serina |
| **Provider 2 Location:** | Onsite |
| **Supervisor/LPHA Consulted:** | |
| **Arrival Time on Scene:** | 12:10 PM |

### Circumstances Prior to Dispatch

| | | | |
|---|---|---|---|
| Was the client on an involuntary hold prior to dispatch? | ☐ Yes | ☒ No | ☐ Unknown |

### Mobile Crisis Response

**Interventions provided by the Mobile Crisis Team** ***(include coordination with other agencies)***

Serina and I found Sage in her car near Juliard Park. We were able to engage her in discussion around her SI and precipitating events. We assessed for continued suicidal thoughts (not wanting to be alive), intent (to die), plan (slowing take bottle of Vicodin - at least 22 pills in bottle) and lethality (risk is high). We attempted to engage Sage in safety planning (getting rid of pills, connecting her to a support person to stay in their home, voluntarily going to CSU), but due to her level of distress and lack of support, she was unable to engage. I placed Sage on a 5150 hold and she agreed to allow us to transport her to the CSU. Serina was able to call ahead to the CSU and coordinate Sage's admission. We drove Sage to the CSU and waited with her until she was admitted onto the unit in order to continue providing support. Team completed the crisis assessment.

### Crisis Planning

Due to level of distress, Sage was unable to engage in planning, but did agree to be transported the CSU to continue receiving support.

| | |
|---|---|
| Disposition of Encounter: | Admitted to CSU |

### Disposition Details:

Sage was admitted to the CSU, where she will receive an assessment, and potentially be psychiatrically hospitalized. Team will follow up with CSU tomorrow to determine outcome of assessment and connect with Sage to discuss potential referrals (Access referral, connection to community therapist, safety parking programs or homeless services).

| | | | |
|---|---|---|---|
| Was the client on an involuntary hold at the end of the encounter? | ☒ Yes | ☐ No | ☐ Unknown |
| Reason(s) for Hold: | ☒ DTS | ☐ DTO | ☐ GD |

# Transportation Mileage & Staff Time

| | | | |
|---|---|---|---|
| Did Mobile Crisis Team provide transport or accompany the client while they were being transported to a treatment setting? | ☒ Yes | ☐ No | ☐ Unknown |
| Miles driven: *(round to the nearest mile)* | 12 | | |
| Provider 1 Transportation Time: | 16 minutes | | |
| Provider 2 Transportation Time: | 16 minutes | | |
| Type of transportation: | County Vehicle | | |

If the clinician (author) of the mobile crisis encounter service is not the same person who provided the transportation service, the secondary staff member will have to document their time separately.

# Mobile Crisis Follow Up Notes

- Note to include:
  - Client received a follow-up check-in within 72 hours of the initial mobile crisis response.
  - Continued support for resolution of the crisis, as appropriate,
  - Updates to the client's crisis safety plan (as needed)
  - Additional referrals to ongoing supports (as needed)
  - If client received a referral to ongoing supports during the initial mobile crisis response, as part of follow-up, it should be documented that the mobile crisis team checked on the status of appointments and continue to support scheduling, arrange for transportation, and provide reminders as needed.
- If follow-up was not done, it must be documented on service note that client could not be reached despite diligent efforts by the mobile crisis teams (as evidenced by service notes of those efforts).

# Example of actual note

**SonomaCntySmartcareQA | 12-26-2023**

**Narrative**

| | | | | | |
|---|---|---|---|---|---|
| **Client Name:** | Sage Perkins | **Client ID:** | 2000877 | **Status:** | Complete |
| **Clinician Name:** | Marcia Williams | **Service:** | Mobile Crisis Follow-Up | | |
| **Date Of Service:** | 03/29/2024 | **Start Time:** | 2:00 PM | **Face to Face Time:** | 24.00 Minutes |
| **Program:** | Mobile Crisis Test Program | | | | |
| **Location:** | Mobile Unit | | | | |

**Documentation Time:** 7 Minutes

**Narrative:**

Called and spoke with client. Sage was discharge from CSU and admitted to CRU on 3/30/24, so she can continue to receive further support. CSU staff supported Sage in scheduling an intake appointment with Access on 4/9, that she says she will attend and CRU will assist with transportation to and from appt. Sage states that she is feeling supported by CRU staff, but she is not ready for discharge yet. She agreed for me to email her some other community resources: housing/shelter lists, safe parking locations, community counseling agencies, YWCA and food banks. Sage stated that she will review the resources with her main counselor at CRU.
Once I email Sage the agreed upon resource list, MST to close her to the program, as she no longer requires MST assistance.

| | | | |
|---|---|---|---|
| **Staff:** | Marcia Williams, MFT | **Signature Date:** | 04/04/2024 |

# Location of Service

- Choose one of the two appropriate locations on *Mobile Crisis Encounter Service Note*:
  - Mobile Unit
  - Mobile Unit w/ Telehealth
- Mobile Crisis Services aren't billable in the following settings due to restrictions in federal law and/or because these facilities and settings are already required to provide other crisis services:
  - Inpatient Hospitals, Emergency Department, Residential SUD treatment and withdrawal management facility, Mental Health Rehabilitation Center, PHF, Special Treatment Program, Skilled Nursing Facility, Intermediate Care Facility, Jails, Prisons, juvenile detention facilities, Other crisis stabilization and receiving facilities
- Reference Locations of service definitions handout for full descriptions

# Respectful Language & Cultural Considerations

RECOVERY-ORIENTED LANGUAGE
LGBTQIA+ CONSIDERATIONS

CULTURALLY RESPONSIVE CARE

# Recovery-Oriented and Respectful Language

- Our job is to help people learn skills and develop supports to get better, not to judge them
- Remember that unconditional positive regard is a vital element of mental healthcare
- Clients are people, not diagnoses (e.g., “She’s a borderline” vs. “She has a diagnosis of Borderline Personality Disorder”)
- Overly clinical and jargon-y language impedes communication
- What does “high-functioning” or “decompensating” actually mean?
- How will your reader know?

# Example Language

From *Recovery Oriented Language Guide 2nd Ed.*, Mental Health Coordinating Council 2018

| Language of Acceptance, Hope, Respect & Uniqueness | Worn-out words |
| --- | --- |
| • Kylie is having a rough time<br>• Kylie is having difficulty with her recommended medication<br>• Kylie's medication is not helping her<br>• Kylie is experiencing unwanted effects of her medication<br>• Kylie disagrees with her diagnosis<br>• Kylie is experiencing … | • Kylie is decompensating<br>• Kylie is treatment resistant<br>• Kylie is uncooperative<br>• Kylie doesn't accept she is mentally ill<br>• Kylie has no insight |

# Example Language

From *Recovery Oriented Language Guide 2nd Ed.*, Mental Health Coordinating Council 2018

| Language of Acceptance, Hope, Respect & Uniqueness | Worn-out words |
| --- | --- |
| • Sam is trying really hard to self-advocate<br>• Sam may need to work on more effective ways of getting his needs met | • Sam is manipulative, irritable<br>• Sam is demanding and unreasonable<br>• Sam has challenging or complex behaviors<br>• Sam is dependent |
| • Ash is choosing not to…<br>• Ash would rather look for other options | • Ash is non-compliant<br>• Ash has a history of non-compliance<br>• Ash lacks insight |

# Particular Documentation Concerns for LGBTQIA+ Clients

- Name in admission forms must match Medi-Cal card

**BUT!**

- Use the name, gender, and pronouns the client uses in your written documentation.

- Be careful making assumptions about a client's gender, pronouns, sexual orientation (or any other qualities!). "Samantha was previously married to a man" does not mean "Samantha is straight."

# Culturally Responsive Care

- Be aware of your own social position and how that may be shaping your response to clients
- Clinical language and models of "health" often pathologize historically marginalized populations and healing practices
- Mainstream white American culture often emphasizes independence at the expense of family, results at the expense of relationships, "being nice" at the expense of discussing problems
- Stay aware of your own social position, especially on axes where you hold more power – and remember that simply by being a "provider," you hold power over clients
- If your client holds more power than you on certain axes, please don't feel you are required to suffer abuse. Talk to your manager/supervisor.

# Questions & Reference Documents

- **Send any documentation related questions to:**
  - BHQA@Sonoma-County.org
- **SCBH Documentation Resources:**
  - https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/documentation-resources
- **Additional SmartCare Links:**
  - Opening Client to MST Program
- **Reference Documents:**
  - BHIN 23-025
  - BHIN 23-068
  - DHCS Mobile Crisis FAQ