Summary of Comments on Draft
Technical Assistance on Documentation
December 2006

Comments were received from 4 individuals representing 4 local systems

| Comment | Response |
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| 1. If we fail to document in a contact note that we sent a letter out to the family, the doctor, whoever, but we have a copy of the letter in the chart, is it still as if the activity did not occur? Granted, we should also write a contact note to document what we did, but isn't the copy of the correspondence also proof of what we did and proof that the activity did occur – and, in some ways, even better proof than a contact note, since it is the actual copy of the letter? I am commenting on this in response to the first bullet under "general rules." An additional thought – if this is true, that we have to document everything we do in a contact note or it did not happen, are the contact notes all that are reviewed during an audit or complaint process? Wouldn't the entire record be reviewed and wouldn't a copy of something give us credit for having done it even if we failed to note that activity in a contact note? | In the case of something like a letter, there must be documentation that it was sent, such as a fax verification/receipt, a notation on the letter of the date it was sent along with the initials of the sender, or a contact note documenting that the letter was sent.<br><br>When a review is conducted as part of an audit or complaint investigation, the child's record as a whole will be reviewed. |
| 2. Child's Record/ID Number – Is there a reason that this has to be required? At this time, we do not use any ID number for our early intervention records (although our CSB assigns a number). When we move to electronic medical records within the next couple of years, we will likely use those numbers but now we do not. I suggest that this be optional and not required. (2) | The Part C Office agrees that the inclusion of the child's record/ID number on contact notes can be optional.<br><br>Change: Delete child's record/ID number from the list of specific content requirements. |
| 3. To Whom the Service Was Delivered –<br>o While this seems to be self-explanatory most of the time since it is the child who has the IFSP, how would we fill out this information when we, for example, talk | The Part C Office agrees that this information needs to be included only for an actual service session and not when a service is being provided on behalf of the child or family (e.g., a phone call to DSS). |

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| with DSS about benefits for a family? Who am I delivering a service to with that particular contact? I am gathering information and not really serving anyone directly. Ultimately I serve the family with that information, but that is saved for another contact note when I document what I share with the family about my DSS call. And, in all cases, wouldn't this requirement be redundant and therefore unnecessary because there will be a clearly written contact note that describes whatever interaction took place? I think this item could be murky. I suggest deleting it.<br><br>o Seems like putting the child's name plus listing who the service was delivered to is redundant. | Please note that not all services are provided to just the child, so it is not redundant to include both the child's name on the contact note and to whom the specific service was provided.<br><br>Change: Move "To whom service was provided" and "who was present" under "Description of what happened during the session." |
| 4. Time at which the service was provided or contact was made – I am wondering why this is a requirement. Unless it is required for insurance purposes (it has not been in the past) or for IFSP documentation purposes (but we don't state in the IFSP what time of day we are going to provide services, so there is no way to cross check this with the IFSP), I suggest that it be optional. (3) | Including the time at which the service was provided or contact was made is beneficial for many reasons. For instance, if a child is not making progress, the time of day services are being provided may be an issue. Without documentation of when services are provided, determining its impact on child progress may be difficult. While the Part C Office feels this is important information to document, we will not require it.<br><br>Change: Delete "Time at which service was provided…" from the list of specific content requirements. |
| 5. Date of note – I am wondering why this is a requirement. We are not required to do this at this point at our agency, although I am guessing it will be an automatic feature of medical records. I suggest that it be optional. | The date on which the note is written is important information to include as part of thorough and accurate documentation.<br><br>Change: Clarify wording as follows: "Date of the note and date of service or contact, if the note is not written on the same date." |
| 6. It will be difficult, if not impossible, to get our private providers through our local hospitals to adopt Part C standards for contact notes as they are meeting their hospital rules for | The Part C Office is not requiring any particular format for contact notes. You will need to work with the hospital provider to determine what Part C documentation requirements are not |

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| therapy documentation for their billing. They cannot have documentation in the hospital records that looks different than other hospital records. I would feel uncomfortable approaching our two hospitals about this as we feel very fortunate that they even share their therapists with us at all and we do not want to jeopardize our relationship with them by having too many requirements. | currently being included in the provider's contact notes and how the Part C documentation requirements can be met within the structure of the hospital record. Your Part C Technical Assistance Consultant is available to assist you with this. |
| 7. This is going to create much more work for the therapists to be this specific in their progress notes. I'm concerned about the financial implication to the locality of this. | Your Part C Technical Assistance Consultant is available to assist you in working with therapists or other providers in order to address financial concerns and to identify strategies for streamlining the contact note process while including the required elements. |
| 8. I suggest that Part C contact notes include everything that is required and leave the information that is not required as optional. The paperwork requirements are mounting and the pressure on service providers to remember every detail is also mounting – the more that is required, the more chances that we will forget something. While consistency and thoroughness is critical in contact notes, requiring unnecessary detail becomes burdensome. | Please note in the responses above that some of the specific content requirements listed in the draft will be deleted. Your Part C Technical Assistance Consultant is available to assist you in identifying strategies for streamlining the contact note process while including the required elements. |
| 9. Regarding contact note checklist, programs use a variety of contact notes on which some of the suggested information would be unnecessary or redundant. For instance, a note that documents a special instruction visit would do well to include all these items. However, a contact note which is written specifically to document a phone conversation or other interaction would not need all this information. Additionally, I am reading "It is acceptable..." to mean that it may be suggested but not required. But, if I am wrong, I don't see the need to place a child's name on both sides of a single sheet of paper, for instance, where it would make sense to place the child's name on each sheet of paper that the contact note is | The Part C Office agrees that some information needs to be included only for an actual "direct" service session.<br><br>Change: Clarify that the items listed under "Description of what happened during the session…" must be included when a service is delivered directly to the child or family. Move all items that apply only to a service delivered directly to the child and family under "Description of what happened during the session" |

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| written. | |
| 10. While a contact note should be completed within 72 hours, this may prove difficult for some providers who may make multiple visits inside of a week and need to take "sketch" notes until he or she has the time to complete a formal contact note. In which way do we actually know when a note has actually been completed anyway? | As indicated in the TA document, it is important to complete contact notes in a timely manner to ensure optimal recall of what occurred and so that the note is available for other team members who may need the information for their service provision to the family. The date the note is written must be given with the provider signature.<br><br>Your Part C Technical Assistance Consultant is available to assist you in identifying strategies for streamlining the contact note process while including the required elements. |
| 11. I think it is a very good idea to standardize documentation as much as possible given the number of compliance issues that will be addressed through the progress notes as reviewed in file reviews. | Thank you for your feedback. |
| 12. Why put title after we sign our name? Can't we just put credentials and have that serve as the qualification? | The provider's credentials do not always indicate in what capacity that individual was providing a Part C service. For instance, an SLP may be writing a contact note in her role as the service coordinator, not the speech-language pathologist. In addition, some providers have credentials in more than one discipline. |
| 13. I have an increasing number of parents who communicate with me by email. I tell each of them that it is not secure per HIPAA but there are some who like the convenience of emailing and don't worry about HIPAA. I only use email when they initiate it. I even have a couple of parents who insist on using email and prefer that I do not want me to call them. I have been printing out emails and putting them into the contact note section. What are the rules about contact notes when it is email correspondence? | If this type of communication is acceptable within your agency, then the Part C Office is okay with using email and printing out the email to document what needs to be included in contact notes. Please follow your own agency's rules about documenting that the family has been fully informed about HIPAA and that the family is okay with corresponding by email. |
| 14. Separate out guidance for Therapy Progress notes from Case Management/Service Coordination notes. It becomes very | The Part C Office agrees that some information needs to be included only for an actual "direct" service session. |

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| confusing to try to have one guidance document cover both since they are very different | Change: Clarify that the items listed under “Description of what happened during the session…” must be included when a service is delivered directly to the child or family. Move all items that apply only to a service delivered directly to the child and family under “Description of what happened during the session” |