Documentation of Service Provision, Including Service Coordination, In Virginia's Part C Early Intervention System

Infant & Toddler Connection of Virginia

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Background

The term "contact note" will be used in discussing below how Part C service provision, including service coordination, is to be documented. The term "contact note" is intended to be interchangeable with other commonly used terms such as "progress note," "case note," or "service coordination note." The single term is used here to avoid confusion, and "contact note" was chosen as that single term since it best conveys the concept of documenting all contact with and on behalf of the child and family. Local Part C systems and local participating agencies and providers are not required to call their documentation contact notes.

Based on findings from record reviews by State Part C staff and requests from local systems and providers for more consistency in documentation requirements, all contact notes must follow the general rules and specific content requirements listed below. A checklist for reviewing contact notes is attached for use by local system managers and program managers in providing oversight and supervision. The checklist should also be used by service providers in self-checking that contact notes are complete. Local systems and providers have the flexibility to determine the exact format of their contact notes, though documentation is expected to be in alignment with Virginia's approach to Part C supports and services rather than with a more medical model of service provision. It is helpful to have a pattern or format to follow in writing contact notes so that all required information is included in the note (including documentation components required by the Department of Medical Assistance Services, DMAS).

The general rules and specific content requirements listed below include Medicaid documentation requirements for therapy visits. The Medicaid Rehabilitation Manual, Chapter VI further discusses the Medicaid requirements associated with contact notes.

Purposes of contact notes

Effective and complete contact notes are critical in order to address the following purposes of such documentation. Part C contact notes are:

- A chronological record of the child's and family's participation in the Part C system (including the supports and services provided to the child and family), the course of intervention, and the child's developmental progress.
  Therefore, thorough contact notes:
  - Provide an objective basis to determine the appropriateness, effectiveness and necessity of intervention, and
  - Assist the IFSP team in assessment and service planning at IFSP reviews and annual IFSPs
- A means for communication among service providers and with the family.
  - Not only do thorough contact notes facilitate communication among current service providers, but they also provide critical information to substitute providers who fill in when the usual provider is ill or on vacation and to new providers who begin services after an IFSP review or annual IFSP.
  - Local systems are reminded that under Part C parents have the right to review their child's record.

- Billing documents
  Contact notes are used for billing purposes and must provide the information required by Medicaid and other third-party payors.
- Monitoring documents
  Contact notes are reviewed by local system managers, program managers, State Part C personnel, and Medicaid personnel to monitor compliance with federal and State requirements and to facilitate quality assurance and improvement. Contact notes that are complete and accurate will assist local systems in documenting compliance and improvements.
- Legal documents
  Contact notes are legal documents and may be used in the investigation of an administrative complaint or in a due process hearing under Part C, or in a court case such as a custody dispute. Again, thorough contact notes are essential in documenting compliance with Part C requirements, provision of supports and services in accordance with the IFSP, reasons for missed appointments, and other contacts and activities completed on behalf of the family.

<u>General rules</u>

- Document all contacts made and all activities completed with or on behalf of the child and family. This includes, but is not limited to, phone calls (including "no answer" or a "voice message left"), face – to – face contacts, and written correspondence. If someone is looking at a child's record and a contact or activity is not written down, then the reviewer must assume that the contact or activity did not occur.
- Use contact notes to provide essential information that is not contained in meeting record forms such as the IFSP.
- Document the reasons for cancellation (whether cancelled by the provider or the family) any time a contact was scheduled and did not occur. The more specificity provided, the more helpful the contact note is for individuals monitoring and/or using contact notes for billing.
- Write legibly.
- Use the provider agency's rules regarding ink color for contact notes. Black ink is preferred since it works best for faxing and copying.
- Provide complete and accurate information about the contact or activity, ensuring that a third party could read the contact note and understand what occurred.
- Record events and observations in a factual, non-judgmental way and avoid subjective comments.
- Use positive statements.
- Use language understood by all team members, including the family. Avoid jargon and abbreviations or explain them in the note.
- Complete contact notes in a timely manner.
  Part C providers are required to comply with their own agency's rules regarding timelines for completion of contact notes. If their agency has no such rules, then the contact note must be completed no more than 72 hours from the time of the contact. Ideally, the contact note should be done immediately following the contact 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.

- Correct errors on handwritten contact notes by drawing a single line through the incorrect information, provide the date of the correction and the initials of the reviser, then add the correct information. Correct errors in electronic documentation by using strike-through and providing the date and initials of the reviser. White-out, or any other means of correction other than that described here, may never be used to change the contact note.

Specific Content Requirements for Part C Contact Notes

For all contact notes:

- Child's first and last name

  It is acceptable to have the child's first and last name on each page of contact notes rather than on each note itself (the name must appear on both sides of the paper if both sides are used for contact notes).
- Type of service provided (special instruction, physical therapy, service coordination, etc.)
- Type of contact (phone, face-to-face, e-mail, etc.)
- Date of the note and date of service or contact, if the note is not written on the same date. If the contact described in the note occurred prior to the date of the note, then the date of the contact should be contained in the body of the note (e.g., "4/5/06 – On 4/4/06 service coordinator participated in Joe's IFSP meeting.").
- Provider signature (with at least first initial and last name) and title of provider. The signature of the provider must be handwritten or electronic; no stamps allowed.

For contact notes documenting a service session with the child and family, also include the following:

- To whom the service was delivered
- Who was present
- Length of the session (in minutes)
- Location/setting (e.g., home, day care, etc.) in which the service was provided
- Information from the family/caregiver about what has happened since the last visit [The contact note should make clear that the information is from the family by using phrases like "as reported by (family member)," or "(Caregiver) reports…."]
- Specific interventions and methods used during the session, referencing all outcomes that were the focus of the intervention
- How the child, caregiver and others who were present participated in the session
- Progress made as related to IFSP outcomes
- Suggestions for follow-up during daily routines, including the following:
  - Support and instruction provided for the family
  - Any adjustments that are needed to intervention strategies and activities

Frequently Asked Questions

1. **If two or more distinct services were provided by two or more people at a single visit, then how should it be documented in the contact notes?**

   Each provider completes a separate contact note documenting the service he/she provided.

2. **If a provider is serving as both the service coordinator and another discipline (such as physical therapist) and addressing both roles during one visit with the child and family, then how should it be documented in the contact notes?**

   Part C providers are required to comply with their own agency's rules regarding documentation when serving in a dual role. However, for purposes of Part C documentation, the provider may complete one contact note for the visit but must address both roles within that note (i.e., designate a service coordination part of the note and a therapy part), and include the amount of time spent on each role.

3. **Would it be appropriate to document in a contact note discussion (including areas of disagreement) that occurred during an IFSP meeting but was not reflected on the IFSP?**

   It would be not only appropriate but recommended that the service coordinator document such discussion in a contact note. When there are areas of disagreement, the contact note would also document the resolution reached or, if the issue was not resolved, the plan for addressing the area of disagreement.

4. **Would it be appropriate to document supports and services recommended by the IFSP team based on the child/family outcomes even if the family did not accept all of those supports and services?**

   It would not only be appropriate but recommended that the service coordinator document the discussion in the contact note. The Service Coordinator is also responsible for having the parents sign a *Declining Early Intervention Services* procedural safeguard form for those services recommended by the IFSP team but declined by the family.

5. **If there is communication related to a child who has been discharged from the local system, what kind of documentation is required?**

   Such communication would require a contact note, which must be filed in the child's record.

6. **If someone other than the service coordinator or other service provider (e.g., a program supervisor or the central point of entry) gets a call from the family, what kind of documentation is required?**

   Such communication would require a contact note, which must be filed in the child's record.

7. **For those providing Part C service coordination through Mental Retardation or Mental Health Targeted Case Management (TCM) funding, are there any additional requirements for contact note documentation?**

   Additional TCM (MR and MH) documentation requirements can be addressed in the Part C contact notes by including:

   - The required case manager/service coordinator face to face contact with the child at least every 90 day period (with a 10 day grace period permitted). The contact note must document that the TCM/service coordinator was in the presence of the individual (the child), assessed satisfaction with services, determined any unmet needs, evaluated the child's status, and assisted with adjustments in the child's services and supports as appropriate.
   - Documentation that medical status is monitored and follow-up occurs quickly for any identified medical or safety concerns. Medicaid TCM puts much more emphasis on the medical status of the child than Part C does. The TCM/service coordinator must also document that they monitor the EPSDT requirements for well baby check-ups to ensure that the child is getting the required screenings per the EPSDT schedule.
   - Documentation that the IFSP/Plan of Care has been reviewed at least every 3 months (this review can be incorporated into an IFSP review). The required quarterly review process includes writing a quarterly review summarizing the review of each provider; reporting on the general status of the child (including health and safety), significant events, progress or lack of progress in meeting the IFSP outcomes; and individual (child) and family satisfaction with services. (There are strict requirements as to when the quarterly reviews must be written and in the record in order to meet billing requirements.)

   For more information on documentation requirements associated with TCM, please visit www.dmas.Virginia.gov and click on the MR Community Services Manual for MR Case Management and MH Community Services Manual for MH Case Management.

Contact Note Checklist

Contents:

For all contact notes:

- ☐ Child's first and last name - on the note or the page
- ☐ Type of service provided (e.g., service coordination, physical therapy, etc.)
- ☐ Type of contact (e.g., phone, face-to-face, mail, etc.)
- ☐ Date of contact note
- ☐ Date of service/contact (if different than date of note)
- ☐ Location/setting in which the service was provided
- ☐ Signature of provider (at least first initial and last name; handwritten or electronic, no stamp)
- ☐ Title of provider

For contact note on a service session with child and family, must also include:

- ☐ To whom the service was delivered
- ☐ Who was present
- ☐ Length of the session in minutes
- ☐ Information from family/caregiver about what has happened since last session
- ☐ Interventions/methods used, referencing IFSP outcomes that were addressed
- ☐ How child, family and others who were present participated in session
- ☐ Progress made on IFSP outcomes
- ☐ Suggestions for follow-up during daily routines, including
  - ☐ Support and instruction provided for the family
  - ☐ Any adjustments needed to intervention strategies and activities

Other:

- ☐ Handwriting is legible
- ☐ Complete and accurate information about the contact or activity
- ☐ Language used can be understood by all team members, including the family.
- ☐ Events and observations are recorded in a factual, non-judgmental way
- ☐ Information is presented in a positive manner
- ☐ Note is completed within agency timeline requirements or within 72 hours of contact
- ☐ Errors on handwritten notes are corrected by a single line through incorrect information, citing date of the correction and initials of reviser, then adding correct information. Errors in electronic documentation are corrected by using strike-through and providing the date and initials of the reviser. White-out, or any other means of correction other than that described here, may never be used to change the contact note.