WRAPAROUND MILWAUKEE **Policy & Procedure**	Date Issued: **9/1/02**	Reviewed: **10/31/14** By: **PE** Last Revision: **10/31/14**	Section: **Care Coordinator**	Policy No: **037**	Pages: **1 of 2** (4 Attachments)
☒ **Wraparound** ☒ **Wraparound-REACH** ☐ **FISS** ☒ **Project O-Yeah**	Effective Date: **1/1/15**		Subject: **PROGRESS NOTES**		

I.   POLICY

It is the policy of Wraparound Milwaukee that all enrollee-related activities provided by Care Coordinators/Transition Coordinator be documented in Synthesis (*Wraparound Milwaukee's IT system*). The Progress Note, as defined in Synthesis, consists of the date of the note, the note text and the writer's signature.

II.   PROCEDURE

A.   All Progress Notes (*see Attachment 1 – Sample Progress Note Entry and Attachment 2 – Crisis and Documentation Guidelines)* must be completed and finalized in Synthesis within ten (10) days of the contact. A hard copy of the Progress Notes are no longer required to be kept in the client file, as they are now part of the electronic record.

B.   Progress Notes are electronically signed by the author. For notes that are not electronically signed, the printed progress notes must be signed with the full name (*or a minimum first initial and last name*) of the writer and his/her credential (*i.e., M.A., B.A., etc*.). If the author of a Progress Note is not available to sign the Note (*i.e., a Care Coordinator/Transition Coordinator unexpectedly leaves an Agency*), and that person cannot be located to acquire the signature, then it is permissible for the Care Coordination/Transition Coordinator's Supervisor or Lead to sign off on the Progress Note as follows: "Kathy Miller, MSW for John Jackson, BS". A Progress Note should be entered into the chart by the Supervisor or Lead, indicating why the Progress Note was signed by someone other than the author.

C.   At minimum, a weekly Progress Note for Wraparound and a bi-weekly Progress Note for REACH, documenting your face-to-face contacts (*or attempts to make a face-to-face contact*) with the family and the youth is required. If a family/caregiver indicates that they do not desire weekly/bi-weekly face-to-face contact, this must be referenced in a Progress Note every month.

D.   No more than a total of 12 hours can be reported within the context of a Care Coordinator/Transition Coordinator cumulative Progress Notes in one day. If an attempt is made to enter more than 12 hours of time, an error message will appear. If more than 12 reportable hours were worked in that day, Supervisors and Leads at the agencies have access to increase the amount of time reported.

E.   When a Care Coordinator/Transition Coordinator is on vacation, sick leave or a planned absence, a Note referencing this must be entered. The Note must indicate the dates the Care Coordinator/Transition Specialist will be gone, the name(s) of the person(s) who will be covering for him/her, and the coverage person's phone number. This Progress Note must be entered **prior** to the Care Coordinator/Transition Coordinator going on leave, vacation, etc.

F.   There must be at least one Child & Family Team (CFT) meeting held per month and this must be documented in a Progress Note. The CFT includes individuals the family will identify along with others such as the Care Coordinator/Transition Coordinator, Child Welfare Worker or Probation Officer, teachers, therapists and other mental health providers. In the months in which a POC Meeting is held, it is not necessary to also conduct a Child & Family Team Meeting, unless otherwise indicated. The Child & Family Team / POC Progress Note and the Child & Family Team/POC Progress Note – ATTEMPTED cannot be combined with any other type of Progress Note. **Both of these Note types must stand alone.** A Coordinated Service Team (CST) meeting can be considered to be a Child & Family Team meeting and should be coded as such on the Progress Note.

When writing a CFT / POC Note, you must discriminate within the context of the Note whether it actually was a CFT or POC meeting.

G. Progress Notes must provide a description of what occurred during the course of the contact (who was present and/or spoken to and their relationship to the youth, the content of the interaction/discussion, where the contact occurred, the type of contact (i.e., phone, face-to-face, written) an impression (if any) that the writer may have regarding the contact, and the outcome of the contact/action plan.

H. Progress Notes must be written in a strength-based and professional manner and reflect progress or lack of progress toward the Plan of Care Need Statements, Family Vision and movement toward transition/ disenrollment.

I. Only those Abbreviations, Symbols and/or Acronyms referenced in the "Wraparound Milwaukee Symbols, Abbreviations & Acronyms" document are permissible to use in the context of a Progress Note.

J. Per HIPAA guidelines, any time protected health information about a youth/family is released (i.e., Plans of Care, Court information, Referrals, etc.), it must be documented. The Care Coordinator has the option to document this on the DISCLOSURE TRACKING LOG (*see Attachment 3)* and/or in the context of a Progress Note. If the Progress Note format is used, then the Note must contain specific required information (*see Attachment 4)* and should be coded as a "Release of Information" note type. If the Disclosure Tracking Log format is used, then all Logs must be filed in the client's chart in the "Intake/Consents" section at the time of disenrollment.
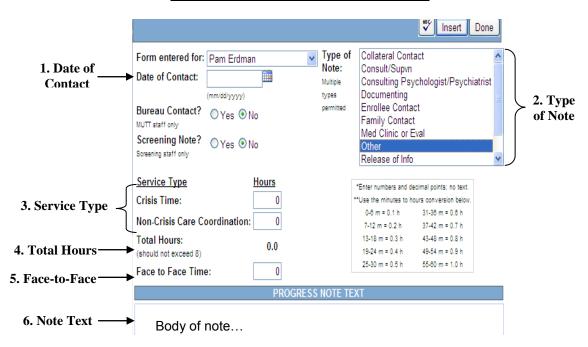
K. **Modifying / Deleting a Signed Progress Note**
Once Progress Notes have been signed, the entry generally cannot be edited or deleted. However, edits can be made in the following instances:

1. If an error is made in the "service type hours" information on a Progress Note, you can click on the "Re-Open" tab and these fields will become editable. Note text cannot be edited. After making your changes, just click on "Update" to resave the Note. The Note will become uneditable again. Users will only see the "Re-Open Note" tab for Notes dated within the past 30 days. Outside of 30 days, the writer will need to call the Synthesis Help Desk at (414) 257-7547.

2. If an incorrect date was entered, contact the Synthesis Help Desk. They will correct the date and put a notation in the record as to this change. If you re-enter and sign the note a second time – your initial note entry cannot be deleted.

3. If an entry was made in the wrong client record, you must: 1) re-enter the note under the correct client name; and 2) contact the Synthesis Help Desk to have the entry retracted from the incorrect file. This will "hide" that incorrect entry from all screens and from all reports. The Synthesis Help Desk will document this change on that hidden record.

4. If an entry was entered with the wrong User ID (*i.e., if someone forgot to re-log in under their own ID on a shared computer*), you must: 1) re-enter the note using the correct User ID; and 2) contact the Synthesis Help Desk to have the incorrect entry retracted from the file. This will "hide" that incorrect entry from all screens and from all reports. The Synthesis Help Desk will document this change on that hidden record.

L. Cutting and pasting emails from others into progress notes is NOT permissible. The Care Coordinator/ Transition Coordinator should summarize the email content within the text of his/her note. Be reminded that only factual information should be referenced/summarized and one should refrain from using verbiage that may have expressed one's personal feelings.

Reviewed & Approved by: *Bruce Kamradt*

Bruce Kamradt, Director

WRAPAROUND MILWAUKEE
Sample Progress Note Entry

1. **Date of Contact** – Date that the contact occurred.

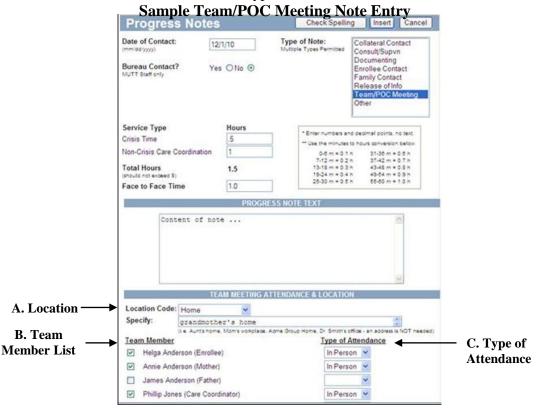2. **Type of Note** – Reflects the type of note to be entered.

   Type of Note Definitions:

   - **Collateral Contact** – ANY type of contact with COLLATERALS ONLY. If the client and/or a family member was a part of the contact, use the "Client and/or Family Contact" code. Include travel time and documentation time for the contact.

   - **Consultation/Supervision** – Consultation/Supervision that the Care Coordinator has with Care Coordination Supervisor/Lead, consulting Psychologist/Psychiatrist, Wraparound Management, etc., that is client-specific. Include travel (if any) and documentation time for the contact.

   - **Consulting Psychologist/Psychiatrist -** ONLY for use by consulting psychologists/psychiatrists.

   - **Documenting** – Use this code if the ONLY work the Care Coordinator is engaging in is completing some form of documentation (i.e., writing a Court Letter, writing a Plan of Care, completing a Provider Referral, doing Change of Placements or Critical Incidents, etc.).

   - **Enrollee (Client) Contact** – ANY type of contact with the identified client alone or with collaterals. Include travel time and documentation time for the contact.

   - **Family Contact** – ANY type of contact with the identified family members or primary caregiver (i.e., foster parent) alone or with collaterals. Include travel time and documentation time for the contact.

     Note: If the client and family are seen together then both Note types should be identified.

   - **Med Clinic or Eval** – ONLY for use by medication clinic staff. If a Care Coordinator attends a medication clinic appointment with a youth/family then the corresponding note should be coded as Enrollee Contact and/or Family Contact.

- **Other** – Use this code if the only service you are documenting is travel time, a no-show or another interaction that has not been previously identified in any other code (i.e., faxing, filing, completing SAR's, printing out paperwork, completing evaluation tools, dropping off documents, writing vacation/leave notes, when reading enrollment packet information on a new client, reading e-mails or texts and listening to voice messages – from enrollee/family or collateral).

- **Release of Information** – *see Attachment 4 – Sample Progress Note for Release of Information.* Use this code when written material is released from a client record and for disclosure of protected health information.

- **Team/POC Meeting-Attempted** – Use this code when the monthly Child & Family Team meeting and/or Plan of Care meeting was attempted, but ended up not occurring for whatever reason. This note type cannot be combined with other note types.

- **Team/POC Meeting** – Used to document the monthly Child and Family Team meetings and/or Plan of Care meetings. Include travel time and documentation time for the meeting. This note type cannot be combined with other note types.

Sample Team/POC Meeting Note Entry

When the "Team/POC Meeting" type of note is selected, several additional fields will appear on the Progress Note screen. These consist of the following:

A. Location Code – a drop down box will appear to identify the actual location of the meeting that includes the following:
- o BMCW Offices
- o Care Coordination Agency
- o Community – Other
- o Correctional Facility
- o Court (*for meetings held at Children's Court Center. For those held in Detention, use the Detention code*)
- o Day Treatment Facility
- o Detention
- o Home

- o Foster Home
- o Group Home
- o Placement Facility–Other (*for meetings held at placement locations other than residential care centers or group homes*).
- o Provider Worksite (*for meetings held at places such as a therapist's office or a clinic. This code is not to be used if the meeting is held at a placement facility where the youth may be residing; for those you should use the placement options available*).
- o Residential Facility
- o School (*for meetings held at the youth's school; note that if the youth is in a day treatment program you would use the Day Treatment code*).
- o Wraparound Offices (*for meetings held at Wraparound Milwaukee Offices, which would include those held in the Wraparound conference rooms or a meeting held in conjunction with a medication clinic*).

After entering in the Location Code, the Care Coordinator must specify the Location. For example, if you select Group Home as the Location Code, then you must specifically list the name of that Group Home in the "Specify" box.

Note: For those POC/Team meetings held in two locations (i.e., the meeting started at home, but was then completed after a court hearing at CCC), please select the Location Code where the majority of the meeting occurred with the majority of the team members. For the POC/Team meetings in which the youth attends by phone/teleconference or video conference (this should occur only in rare extenuating circumstances), the Care Coordinator should choose the Location Code as to where the youth resides (i.e., Residential Facility).

B. Team Member List –list will appear just as it does on the POC Needs Entry screen. Check those members that attended the meeting. You are able to manually enter additional team members that were present, in addition to their relationship to the youth.

C. Type of Attendance – indicate the type of attendance for each team member (i.e., In Person, Phone/Teleconference, Video Conference [should be rarely used]). Synthesis will default to the person being physically present, so you will only have to update this area if the team member attended by Phone or Video Conference.

3. **Service Type** – Of your Total Hours reported, break down the number of Crisis and Non-Crisis hours provided. See CRISIS DOCUMENTATION GUIDELINES (*see Attachment 2)* for an explanation of what type of contacts/activities can be attributed to crisis time.

4. **Total Hours** – The total amount of time documented in the Note. Total hours are automatically calculated.

5. **Face-to-Face Time –** The part of the Total Hours that was face-to-face with the youth, family member and/or primary caregiver. This time must be less than or equal to the Total Hours reported.

6. **Progress Note Text** – The body of your Note.

MEDICAID USES THE FOLLOWING DEFINITIONS (per § DHS 34)

1. **"Crisis"** means "a situation caused by an individual's apparent mental disorder that results in a high level of stress or anxiety for the individual/persons providing care for the individual or the public that cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual."
2. **"Crisis Plan"** means "a plan prepared under § DHS 34.23 (7) for an individual at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs."
3. **"Emergency Mental Health Services"** means "a coordinated system of mental health services that provides an immediate response to assist a person experiencing a mental health crisis."
4. **"Response Plan"** means "the plan of action developed by program staff under §DHS 34.23 (5) (a) to assist a person experiencing a mental health crisis."
5. **"Stabilization Services"** means "optional emergency mental health services under § DHS 34.22 (4) that provide short-term, intensive, community-based services to avoid the need for inpatient hospitalization."

Activities to be coded as Crisis Time

Covered services vary by individual, because the definition of a Crisis is different for each person. Activities you should include as "crisis time" on your Progress Notes would include the following:

1. All <u>direct</u> contact (phone or face-to-face) with the enrollee, the parent/guardian, or the current caregiver.
2. Any time spent in responding to the enrollee's needs regarding a disruption in placement.

Activities to be coded as NON-Crisis Time

All other time, including all contacts with collaterals, documentation time, travel time, reading/responding to/writing e-mails or text messages, leaving/listening to voice messages, etc., should be listed as "non-crisis time" on Progress Notes.
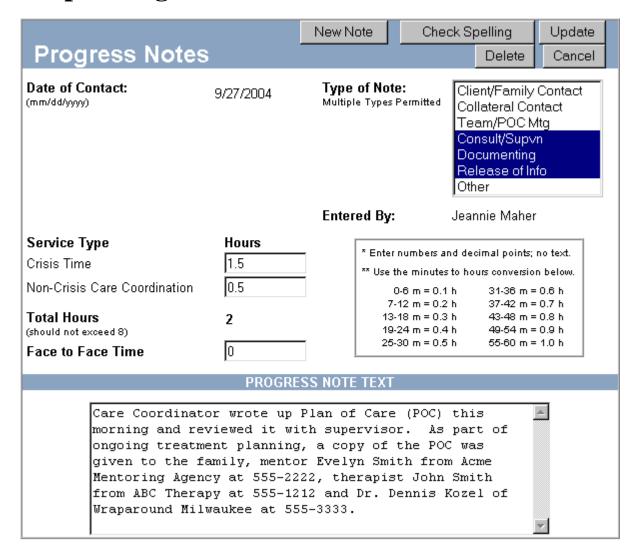
REVISED: 7/26/12, 10/31/14

Wraparound Milwaukee
PROTECTED HEALTH INFORMATION
DISCLOSURE TRACKING LOG

Client Name:		Date of Birth:				
e Received	*(Include: name/agency and address or phone)* **Individual Requesting Information**	**Purpose of Disclosure**	**Disclosure Type**	**(One line for per disclosure.) Information or Document/s Disclosed**	**Date Disclosed**	**Disclosed By**
			Auth on File: ☐ Yes ☐ No ☐ Written Material ☐ Oral			
			Auth on File: ☐ Yes ☐ No ☐ Written Material ☐ Oral			
			Auth on File: ☐ Yes ☐ No ☐ Written Material ☐ Oral			
			Auth on File: ☐ Yes ☐ No ☐ Written Material ☐ Oral			
			Auth on File: ☐ Yes ☐ No ☐ Written Material ☐ Oral			
			Auth on File: ☐ Yes ☐ No ☐ Written Material ☐ Oral			
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			Auth on File: ☐ Yes ☐ No ☐ Written Material ☐ Oral			
			Auth on File: ☐ Yes ☐ No ☐ Written Material ☐ Oral			

PURPOSE OF DISCLOSURE KEY

AR=Agency Referral   COP=Change of Placement   CR=Court Report   F=Financial Referral Forms   POC=Plan of Care   O=Other (Specify)

Use this form to record all written material released from a client record and for disclosure of protected health information when there is NO signed authorization for the information to be release. This form is to be included as part of the client record at disenrollment.

Sample Progress Note for Release of Information

1. Select "Release of Info" as the Type of Note. More than one Type of Note can be selected. If the Progress Note covers multiple service types, select all of the relevant Note types.
2. Document your time as usual.
3. Within the body of the Progress Note, include:
    a. Reason for the Release (i.e., As part of ongoing treatment planning...)
    b. Who the information was released to (i.e., name, agency, address and/or phone number)
    c. What was released (i.e., Plan of Care, Court Letter, etc.)