

 WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 9/1/02	Reviewed: 9/25/09 By: PE Last Revision: 9/30/09	Section: ADMINISTRATION	Policy No: 037	Pages: 1 of 2 (4 Attachments)
	<input checked="" type="checkbox"/> Wraparound <input checked="" type="checkbox"/> Wraparound/REACH <input type="checkbox"/> FISS	Effective Date: 1/1/10	Subject: PROGRESS NOTES		

I. POLICY

It is the policy of Wraparound Milwaukee that all client-related activities provided by Care Coordinators 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 Case Management Definitions and Documentation Guidelines*) must be completed and finalized in Synthesis within seven (7) working days of the contact.
- B. Every client file must have a Progress Note section that includes a printout of all completed, finalized and signed Notes. Progress Notes must be filed in each client's chart by the 10th day of the following month (i.e., June Notes must be filed by July 10th). Charts must NOT contain any Progress Notes in draft form. **Please make sure that spelling and grammar have been fully checked for accuracy before finalizing the Note.**
- C. 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.) when the electronic signature feature is not used. If the electronic signature feature was not used and if the author of a Progress Note is not available to sign the Note (i.e., a Care Coordinator unexpectedly leaves an Agency), and that person cannot be located to acquire the signature, then it is permissible for the Care Coordination 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 Client's Chart by the Supervisor or Lead, indicating why the Progress Note was signed by someone other than the author.
- D. At minimum, a weekly Progress Note 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 face-to-face contact, this must be referenced in a Progress Note every month. The Care Coordinator is also encouraged to indicate this in the Plan of Care Family Narrative updates.
- E. Not more than a total of 12 hours can be reported within the context of a Care Coordinator's cumulative Progress Notes in one day. If an attempt is made to enter more than 12 hours of time, an error message will show up on the Synthesis screen directing the Care Coordinator to contact the Synthesis Help Desk. The Help Desk will be able to enter the hours for the Care Coordinator or make corrections to the hours reported on other notes entered that day.
- F. When a Care Coordinator is on vacation, sick leave or a planned absence, a Note referencing this should be entered. The Note should indicate the dates the Care Coordinator 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 should be entered **prior** to the Care Coordinator going on leave, vacation, etc. (See Client Contact Policy #032, B.4.a.,b., & c. for additional information.)
- G. 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, 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 cannot be combined with any other type of Progress Note. A Coordinated Service Team (CST) meeting can be

WRAPAROUND MILWAUKEE

Progress Notes Policy

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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 and all those who were present at the meeting should be listed.

- H. 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.
- I. 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 disenrollment.
- J. 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.
- K. Per HIPPA 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.
- L. Re-Opening a Progress Note.
If an error is made in the “Note Type” or “Time Reported” on a finalized Progress Note, you can click on the “Re-Open” tab and the Note Type/Time Reported 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 Help Desk at (414) 257-7547.

Reviewed & Approved by: _____



Bruce Kamradt, Director

WRAPAROUND MILWAUKEE
Sample Progress Note Entry

Progress Notes [Check Spelling] [Insert] [Cancel]

Date → **Date of Contact:** (mm/dd/yyyy) **Type of Note:** Multiple Types Permitted

Type of Note →

Service Type { **Service Type** **Hours**

Crisis Time	<input type="text" value="0"/>
Non-Crisis Care Coordination	<input type="text" value="0"/>

Total Hours → **Total Hours** (should not exceed 8)

Face-to-Face → **Face to Face Time**

Note Text → **PROGRESS NOTE TEXT**

Body of note...

* Enter numbers and decimal points; no text.
 ** Use the minutes to hours conversion below.

0-6 m = 0.1 h	31-36 m = 0.6 h
7-12 m = 0.2 h	37-42 m = 0.7 h
13-18 m = 0.3 h	43-48 m = 0.8 h
19-24 m = 0.4 h	49-54 m = 0.9 h
25-30 m = 0.5 h	55-60 m = 1.0 h

- Date of Contact** – Date that the contact occurred.
- Type of Note** – Reflects the type of Note to be entered. Include documentation time and travel time (if any) for the Note type within the same Progress Note. For example, if you spent 1.5 hours in a Plan of Care Meeting, 0.5 hours traveling to the meeting, and another 1.5 hours writing the Plan of Care, the entire 3.5 hours should be documented under “Team Meeting/POC”. You **DO NOT** need to enter a separate Note using the “Documentation Only” Note type. Use “Documentation Only” when the service you are engaging in **ONLY** consisted of Documentation with no other type of contact (i.e., writing a letter to the Court, completing a Change of Placement form {COP}, etc.)

Type of Note Definitions:

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 (i.e., phone contacts, weekly visits, etc.). 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.*

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.

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.

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

Documentation Only – Use this code if the ONLY work the Care Coordinator was engaging in was completing some form of documentation (i.e., writing of a Court Letter when no other contact with the family and/or collaterals was involved, writing a Plan of Care on a day OTHER THAN the actual Plan of Care date, etc.)

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.

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).

3. **Service Type** – Of your Total Hours reported, break down the number of Crisis and Non-Crisis hours provided. See CRISIS CASE MANAGEMENT DEFINITIONS AND DOCUMENTATION GUIDELINES (*see Attachment 2*) for an explanation of what type of contacts/activities can be attributed to crisis time. Your hours reported in these two boxes MUST equal the total hours reported below.
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 or primary caregiver. This time must be less than or equal to the Total Hours reported.
6. **Note Text** – The body of your Note.



Crisis Case Management

Definitions and Documentation Guidelines

REVISED: September 2009

MEDICAID USES THE FOLLOWING DEFINITIONS (taken from HFS 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 s.HFS 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 s.HFS 34.23 (5) (a) to assist a person experiencing a mental health crisis.”
5. **“Stabilization Services”** means “optional emergency mental health services under s.HFS 34.22 (4) that provide short-term, intensive, community-based services to avoid the need for inpatient hospitalization.”

Covered Services

1. Phone or face-to-face contacts.
2. Travel and documentation time. *Note: Travel time is NOT billable if no covered service is provided (i.e., traveling to the family home for crisis response, but the family is not home).*
3. **All services billed as crisis MUST BE DOCUMENTED in a Progress Note following the guidelines outlined below.**

MEDICAID DEFINED CRISIS SERVICES

1. The development of the Response Plan (i.e., Reactive Crisis Plan and Crisis Domains in the initial Plan of Care {POC}).
2. Reviewing and updating the Response Plan and development, review and updating of the Crisis Plan.
3. Follow-up or linkage interventions to meet the following goals:
 - a. Relieve the recipient’s immediate distress in a crisis or pre-crisis.
 - b. Reduce the risk of a worsening crisis.
 - c. Reduce the risk of physical harm to recipient or others.
 - d. Resolve or manage family crises to prevent out-of-home placements of youth, improve the youth’s and family’s coping skills, and assist the family in using or obtaining ongoing mental health and other supportive services.
 - e. Assist in making the transition to the least restrictive level of care.
 - f. Provide evaluation, referral options and other information to a recipient or others involved with the recipient.
4. Coordination of resources needed to respond to crisis situations.
5. Direct provision of professional supports identified on the Response Plan or Crisis Plan provided on a face-to-face basis or over the phone.

Care Coordinator Activities Billable as Crisis

1. The initial visits with the Child & Family Team while an initial Crisis Plan is formed or basic crisis/safety needs are being attended to. Crisis Plans are for youth who are found to be at high risk for recurrent mental health crises.

2. Listening to and documenting the family’s story and developing a family vision when developing the Crisis Plan and Crisis Domain of the initial Plan of Care.
3. Development of the Reactive Crisis Plan and Crisis Domains of the initial Plan of Care.
4. Updates and revisions to the Reactive Crisis Plan and Crisis Domains of the Plan of Care.
5. Client-specific coordination regarding crisis and safety planning or transitioning the youth to a less-restrictive setting. This could be with:
 - a. Your Supervisor and/or Lead Worker.
 - b. Your Court Liaison.
 - c. MUTT staff.
 - d. A consulting Psychiatrist or Psychologist who reviews the Plan of Care.
 - e. High Risk Consultations.
 - f. Out-of-Home Reviews.
 - g. Bureau and/or Probation staff.
6. Coordination of service provision with Providers and community resources specific to crisis/safety issues or transition to the least restrictive level of care.
7. Court hearings specific to the youth’s Reactive Crisis Plan or Crisis Domains in the Plan of Care.
8. Contacts with collaterals (*i.e., school, foster parents, service providers, family supports, etc.*) relative to meeting needs in the youth’s Reactive Crisis Plan or Crisis Domains of the Plan of Care.
9. Emails, whether sending or receiving/reading, if related to client care/services, can be billed under non-crisis or crisis time, depending on the content of the email.
Example: If you receive a client-related email from a Crisis 1:1 Provider that is inquiring about a strategy to be used in assisting with ameliorating a crisis, the time spent reading and responding to this email can be recorded as crisis time within the context of the Progress Note that you will need to write, stating that you received and responded to this email. When you write your Progress Note, it is fine to cut and past the email into the context of your note, if appropriate to do so.
 The “Type of Note” used would relate to the type of email correspondence it was (*i.e., if a collateral contact emailed you information about a client and you responded, then your Note Type would be identified as a “Collateral Contact”*).
 Emails that you receive/send that do not have crisis-related content should be recorded under non-crisis care coordination time.
10. Reviewing or writing reports relating to crisis/safety issues or transitioning a youth to a less-restrictive level of care (*i.e., Out-of-Home Authorizations, Court Letters, Change of Placements, Critical Incidents, etc.*).
11. A Care Coordinator responding with MUTT staff to a crisis situation, if it is necessary for two staff to be with the youth and family.
12. Anytime the Care Coordinator is the person carrying out a strategy within the Reactive Crisis Plan or Crisis Domains of the Plan of Care. The Care Coordinator is the actual “Crisis Stabilizer”.
13. Travel time to provide or coordinate any of the services listed above.
14. Documentation of any of the services listed above.

Care Coordinator Activities Billable as Case Management, but NOT as Crisis

1. Crisis services may not be billed for any time a youth is in Secure Detention or Jail. All time spent working with the youth, family and other Team members while a youth is in either of these placements must be documented as regular case management, even if the service Provider falls under the above crisis categories.
2. Completion of evaluation tools.
3. Development of and updates to non-crisis domains of the Plan of Care.
4. Coordination of service provision to address non-crisis related needs.
5. Contacts with collaterals to address non-crisis related needs.
6. Entry of Service Authorization Requests.
7. Attendance at the Family Orientation.

8. Faxing, filing, printing, mailing or dropping off documents.
9. Time spent gathering signatures or other attachments for documents.
10. Travel and transportation time is not billable as crisis unless a crisis service (as *defined above*) was provided.
11. Documentation of any of the services listed above.

Care Coordinator Activities Not Billable as Case Management OR Crisis

1. Monthly Wraparound Care Coordinator training sessions.
2. Weekly Agency team meetings that are not client-specific.
3. General training sessions and inservices (*i.e., care coordination training, presentations on youth with ADHD or Eating Disorders, etc.*).
4. Participation in general discussions about adolescent behaviors/family dynamics that are not specific to any youth/families you may be working with.
5. ANY consultation or meeting that is not client-specific.
6. Gathering community resource information that is not client-specific.

Billing for More Than One (1) Person Providing a Crisis Service

Generally, only one person may document the same crisis response time. Exceptions to this are when multiple staff are needed to ensure the recipient's or the Provider's safety. Examples would be:

1. When more than one person is in crisis (*i.e., child AND caregiver*), and two people have been sent to respond to the crisis situation.
2. When transitioning a youth in crisis to a placement to which the youth may strongly object (*i.e., secure detention, shelter or other placement facility*).
3. When responding to a crisis in which the Care Coordinator – based on his/her knowledge of the family – can reasonably assume that a volatile or risky situation may result.
4. When the Care Coordinator is contacted by MUTT to assist in alleviating a crisis situation.

Situations when two Care Coordinators should NOT both document crisis time include the following:

1. New staff “shadowing” of seasoned Care Coordinators during orientation and training.
2. In-the-field supervision or other observation by peers.

Crisis Progress Note Documentation Requirements

1. A Progress Note is required for each contact billed as crisis. All Progress Notes must include:
 - a. Date and location of service.
 - b. Time spent in service delivery, separating out crisis time and face-to-face time.
 - c. Whether the contact was face-to-face, via phone or written.
 - d. A **detailed** summary of the contact or service provided.
 - e. Crisis notes must specifically reference needs that are being addressed in the Reactive Crisis Plan or crisis-designated portions of the Plan of Care. Documentation must sufficiently describe the crisis situation being resolved, or how the intervention meets one of the Medicaid definitions of a crisis service (*i.e., relieving the youth's immediate distress in a crisis or pre-crisis situation, assisting in transitioning the youth to the least restrictive level of care, preventing out-of-home placement for the youth, etc.*).
 - f. Notes should be specific and detailed enough to allow the reader to clearly see the “crisis connection” to an intervention/contact. For example, instead of simply documenting “home visit with James and mother”, you would document “made a home visit after being called by mom because James was being threatening toward her” – and then you would describe in detail what you did while on the home visit that de-escalated the situation and prevented mom from requesting James' removal from the home.
2. Signature of writer.



Wraparound Milwaukee
 PROTECTED HEALTH INFORMATION



DISCLOSURE TRACKING LOG

Client Name:			Date of Birth:			
Date 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Written Material <input type="checkbox"/> Oral			
			Auth on File: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Written Material <input type="checkbox"/> Oral			
			Auth on File: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Written Material <input type="checkbox"/> Oral			
			Auth on File: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Written Material <input type="checkbox"/> Oral			
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			Auth on File: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Written Material <input type="checkbox"/> Oral			
			Auth on File: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Written Material <input type="checkbox"/> Oral			

PURPOSE OF DISCLOSURE KEY
 AR=Agency Referral COP=Change of Placement CR=Court Report F=Financial Referral Forms POC=Plan of

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

Progress Notes		New Note	Check Spelling	Update										
		Delete	Cancel											
Date of Contact: (mm/dd/yyyy)	9/27/2004	Type of Note: Multiple Types Permitted	<ul style="list-style-type: none">Client/Family ContactCollateral ContactTeam/POC MtgConsult/SupvnDocumentingRelease of InfoOther											
		Entered By:	Jeannie Maher											
Service Type	Hours	<p>* Enter numbers and decimal points; no text. ** Use the minutes to hours conversion below.</p> <table border="0"><tr><td>0-6 m = 0.1 h</td><td>31-36 m = 0.6 h</td></tr><tr><td>7-12 m = 0.2 h</td><td>37-42 m = 0.7 h</td></tr><tr><td>13-18 m = 0.3 h</td><td>43-48 m = 0.8 h</td></tr><tr><td>19-24 m = 0.4 h</td><td>49-54 m = 0.9 h</td></tr><tr><td>25-30 m = 0.5 h</td><td>55-60 m = 1.0 h</td></tr></table>			0-6 m = 0.1 h	31-36 m = 0.6 h	7-12 m = 0.2 h	37-42 m = 0.7 h	13-18 m = 0.3 h	43-48 m = 0.8 h	19-24 m = 0.4 h	49-54 m = 0.9 h	25-30 m = 0.5 h	55-60 m = 1.0 h
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25-30 m = 0.5 h	55-60 m = 1.0 h													
Crisis Time	1.5													
Non-Crisis Care Coordination	0.5													
Total Hours (should not exceed 8)	2													
Face to Face Time	0													
PROGRESS NOTE TEXT														
<p>Care Coordinator wrote up Plan of Care (POC) this morning and reviewed it with supervisor. As part of ongoing treatment planning, a copy of the POC was given to the family, mentor Evelyn Smith from Acme Mentoring Agency at 555-2222, therapist John Smith from ABC Therapy at 555-1212 and Dr. Dennis Kozel of Wraparound Milwaukee at 555-3333.</p>														

1. Select "Release of Info" as the type of Note. More than one Note type can be selected, so 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. The 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.)