**Policy Title: Documentation and Progress Notes**

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| **Policy Owner:** Senior Business Analyst<br>**Policy Originated by**: Program | **Date Written:** 10/1/13 |
| **Applicable Programs:** All Programs | **Date Reviewed and Approved by PLT:** 3/11/14, 03/07/17, 5/27/20, 4/14/21, 10/13/21 |
| **Statutory or Regulatory Citation:**<br>Minn. Stat. 245D.095<br>Minn. R. 9505.2175<br>DHS rehab services 485.711; 485.711 (a); 485.711(b)<br>Medicare/Medicaid<br>Hennepin County Contract and expectations<br>MHCP Provider Manual | **Signature if needed:** |

**Policy:** It is the policy of St. David's Center that Staff/Providers document services rendered to clients pursuant to service and/or funding requirements. All documentation, including Progress/Daily Notes, will meet minimum content standards as established by the Minnesota Administrative Rules, appropriately identify St. David's Center as the provider, where required, and be maintained and released in accordance with HIPAA and Minnesota data practices laws.

**Procedure:**

**General Documentation Procedure**

1. The content and format of service recipient and program records will be uniform and legible.
2. St. David's Center will keep a written or electronic register, listing in chronological order the dates and names of all persons served by the program who have been admitted, discharged, or transferred, including service terminations initiated by the license holder and deaths.
3. St. David's Center will maintain a record of current services provided to each person on the premises where the services are provided or coordinated.

A. When the services are provided in a licensed facility, the records must be maintained at the facility, otherwise the records must be maintained at the license holder's program office.

4. Records will include the following information for each person:

A. an admission form signed by the person or the person's legal representative that includes

i. identifying information, including the person's name, date of birth, address, and telephone number; and

ii. the name, address, and telephone number of the person's legal representative, if any, and a primary emergency contact, the case manager, and family members or others as identified by the person or case manager;

B. service information, including service initiation information, verification of the person's eligibility for services, documentation verifying that services have been provided as identified in the coordinated service and support plan or coordinated service and support plan addendum, and date of admission or readmission;

C. health information, including medical history, special dietary needs, and allergies, and when the license holder is assigned responsibility for meeting the person's health service needs:

i. current orders for medication, treatments, or medical equipment and a signed authorization from the person or the person's legal representative to administer or assist in administering the medication or treatments, if applicable;

ii. a signed statement authorizing the license holder to act in a medical emergency when the person's legal representative, if any, cannot be reached or is delayed in arriving;

iii. medication administration procedures;

iv. a medication administration record documenting the implementation of the medication administration procedures, and the medication administration record reviews, including any agreements for administration of injectable medications;

v. a medical appointment schedule when the license holder is assigned responsibility for assisting with medical appointments

D. the person's current coordinated service and support plan or that portion of the plan assigned to the license holder;

E. copies of the individual abuse prevention plan and assessments;

F. a record of other service providers serving the person when the person's coordinated service and support plan or coordinated service and support plan addendum identifies the need for coordination between the service providers, that includes a contact person and telephone numbers, services being provided, and names of staff responsible for coordination;

G. documentation of orientation to service recipient rights and maltreatment reporting policies and procedures;

H. copies of authorizations to handle a person's funds;

I. documentation of complaints received and grievance resolution;

J. incident reports involving the person;

K. copies of written reports regarding the person's status, progress review reports, progress or daily log notes that are recorded by the program, and reports received from other agencies involved in providing services or care to the person; and

L. discharge summary, including service termination notice and related documentation, when applicable.

M. For each client under the age of 18 the 'Tracking Children's Mental Health Outcomes Measures' Standard Operating Procedure will be followed with related documentation in each client file.

**Center-Based Therapy and Supports and Community-Based Therapy and Supports Documentation Procedure**

1. Staff/Providers will document each occurrence of a health service provided as condition for payment.
   A. Such documentation may include timesheets, progress notes, case notes, contact log entries , daily notes and/or data sheets submitted by St. David's Center per service requirements.
   B. All documentation, including Progress Notes/ Case Notes/Contact Log entries/Daily Notes, will be legible.

2. Each Progress/ Case/Daily Note or Contact Log Daily Note entry will contain the following information:
   A. Date of service;
   B. Date entry is made;
   C. Type of service provided;

D. Length of service in clock time (if amount paid depends on length of service) or units of service;
E. Persons present when service was delivered;
F. Signature and title of the person who provided the service; and
G. When applicable, the countersignature of the supervisor.

3. When a Progress/Daily Note is used to document a therapy session, the entry will:
   A. Document the client's progress or response to treatment or interventions; Documentation shall be completed within 1-2 business days. In the event of extenuating circumstances, supervisors may approve a longer completion time, however, chronic and/or patterns of delays in completion of paperwork may be an indication of a performance issue and will be addressed as such
   B. For any mental health services in which sessions include different types of services provided on the same day, (i.e. individual and family skills) a session Progress Note will be written for each type of service;
   C. Describe what happened during the session, specific goals addressed and interventions used, response of client to intervention and plan moving forward.
4. When a CMHCM Case Note or Contact Log entry is made the entry will include the required elements in items 1 – 3 above as well as:
   A. Face-to-Face Case Note entry:
      a. Specify if the contact was through telehealth and if so what form (videoconferencing or telephone), and the location of each participant
      b. The start and end time of each contact
      c. Identify if the child/youth was present and if not, why
      d. If applicable, identify why the visit was not 45 minutes in duration
      e. Use key words in each goal area addressed: Assess, Plan, Refer, Link, Coordinate, Monitor, or Follow Up
      f. A summary of key information in each goal area
      g. Include the plan for next contact with the child and/or caregivers
      h. Have complete documentation in all other areas of the template

   B. When making a Contact Log entry:
      a. Indicate if the child/youth was involved
      b. Include identification of the goal area(s) addressed by the activity taking place
      c. Include the start and end time with the duration of the activity
      d. Summarize the activity which took place – if it is travel time, it is only necessary to document the reason the travel time was longer than typical
      e. Have complete documentation in all other areas of the template

5. Detailed Documentation Procedures
    A. Progress/Daily Notes will indicate persons other than the client by their relationship to the client, not by name for mental health records. For example, "Met with Jane and her mother for family therapy."
    B. Progress/Daily Notes will document any referrals made for other services.
    C. Progress/Daily Notes will describe client strengths and limitations in achieving Treatment Plan and/or Plan of Care goals and objectives. For example, "Jane continues to struggle with depressive symptoms, however, notes that she is now taking her antidepressants as prescribed."
    D. Progress/Daily Notes will document when a client misses an appointment.
    E. For sessions in which Staff/Provider travel time is charged, travel time to the session and travel time from the session shall be noted as two distinct times, rather than totaled.
    F. Progress/Daily Notes will be signed by the provider and include the clinical supervisor's signature, when necessary. Signatures will include professional credentials when applicable.

**Procedures for non-compliance of above noted standards and procedures**:

1. For any program area that a timesheet or reimbursement serves as a source document:
    A. Because a timesheet or reimbursement form serves as the source document for billing, formal documentation must be submitted with the employee timesheet.
    B. Such documentation must cover the date of service in accordance with the St. David's Center Timesheet Policy.
    C. If documentation is not provided according to policy, disciplinary actions may result, up to and including:
        i. Verbal warning;
        ii. Corrective action;
        iii. Formal report to appropriate licensing/supervisory board; and/or
        iv. Termination.

2. All Other Programs that Bill to Third Party Insurance
    A. Appropriate and timely documentation is required within 24 hours of session completion or the next business day for sessions that occur prior to weekends.
    B. Documentation must cover the date of service(s) in accordance with the St. David's Center Timesheet Policy.

3. Supervisors and/or Program Coordinators will follow the below outlined procedure in the event of non-compliance.
   A. If a timesheet is submitted without corresponding documentation, the Staff/Provider's immediate supervisor will remind Staff/Provider by phone or e-mail that documentation is required and must be submitted in conjunction with timesheets.
   B. If documentation has not been received within one (1) week of the phone or mail reminder, a corrective action letter will be sent.
   C. If documentation has not been received within thirty (30) days of service, a formal complaint may be filed with the appropriate licensing/supervisory board (i.e. Social Work, Marriage & Family Therapy, Behavioral Health & Therapy), and termination will be considered.
   D. Termination of employment.

4. Upon an employee's resignation, it is the responsibility of that employee to ensure the records are up to date and complete prior to the last day of employment. In the event a client record is found to be incomplete, this may result in a lack of good standing with St. David's Center and impact any future rehire capability and as applicable a report to licensing board of the employee.

5. St. David's Center may bypass any or all of the procedural steps set forth in section 3 immediately above if such action is deemed necessary due to the persistent or severe nature of the issue at hand.

**Reference or Attachment:**