Title: Progress Note Documentation Procedure

Prepared By: Clinical Director

Purpose:

To define the process and protocols for documenting clinical progress notes.

Scope:

This procedure applies to all employees (including full-time employees, part-time employees, contractual clinical providers, volunteers, students, and/or interns) of Huron Behavioral Health (HBH) and all consumers served.

Information:

- The delivery of services is documented in the consumer's case record using the progress note form in the Electronic Medical Record (EMR) system.
- Progress notes may be generated by either clinical staff or clerical staff. Clinical staff progress notes typically record the consumer's progress toward the stated goals, objectives, and team assignments as identified through the person-centered planning process in their Individual Plan Of Service (IPOS).
- Additionally progress notes are used to document activities prior to the development of the IPOS, such as documenting initial activities from the time of the first contact, intake assessment, first scheduled appointment, etc. Clerical staff will generate progress notes which capture the activities in which state reporting parameters require the record-keeping of such actions.
- There are two (2) types of progress notes, direct and support (support progress notes are not billable). In a "direct contact", the worker must meet face-to-face with the consumer. "Support contacts" may include telephone contact(s) with consumer, agencies, or other persons regarding the consumer's status or treatment without the consumer present. Any contact that is made with/for a consumer that is in relation to authorized services (as defined in the IPOS and in alignment with the Medicaid Provider Manual), must be documented on a progress note and coded (for billing purposes) as a contact (either direct or support).

Procedure:

1. Contacts are to be provided in accordance with the frequency, amount, and duration defined in the individual's IPOS and documented promptly (typically within 24 business hours) of the service (see also "Person-Centered Planning Policy" QI.1.05 and "Person-Centered Planning Process and Individual Plan Of Service (IPOS) Procedure" QI.2.18).
2. Staff will document the consumer's progress (or lack of progress) on the progress note form in the EMR system each time a service is provided.
3. Staff will document the following information (as applicable) on the progress note:
    - Consumer name, case number, service codes, place of service, address, etc.
    - Goals and progress toward defined goals (as defined in the IPOS)
    - Mental status and/or Observations
    - Medications compliance (if applicable)
    - Behavioral concerns
    - Presenting issues
    - Interventions
    - Other issues as pertinent/applicable
4. Concurrent documentation is encouraged, but in all cases, progress notes should be completed within twenty-four (24) hours of the contact.
5. Staff should also document (in the case record) consumer cancellations and/or no-shows, as well as staff cancellations.

Definitions/Acronyms:

COA – Council on Accreditation
EMR – Electronic Medical Record
HBH – Huron Behavioral Health
IPOS – Individual Plan of Service
PCP – Person Centered Plan

Forms:

Progress Note Form (in EMR)

Records:

Progress Notes are retained in the consumer's case record in accordance with the "HBH Record Storage and Retention Policy" (QI.1.23).

Reference(s) and/or Legal Authority

COA standards
QI.1.05 Person-Centered Planning Policy
QI.1.23 HBH Record Storage and Retention Policy
QI.2.18 Person-Centered Planning Process and Individual Plan Of Service (IPOS) Procedure

Change History:

Change Letter	Date of Change(s)	Changes
None		Old procedure brought into new Controlled Documentation format with minimal content changes.
A	09/11/07	Revised to include the new regional Progress Note Form (90-1008), removed all references to old HBH progress note forms (90-208 & 30-001), added "EMR" to "Acronym" and "Records" sections, revised bullets in #3 to comply with items on new Progress Note form, revised some wording to clarify without changing content, removed #7 (Record keeping) as it was redundant with "Records" section of Policy, added hyperlinks
B	02/21/13	Reviewed and revised to comply with 8th edition COA standards – removed COA chapter-specific (G9) reference, combined numbers 2 & 3, changed "appropriate" to "responsible" in # 2 and added "within 24 business hours", added "Business" to #6, reworded #8which referred to the paper form process and changed to reflect new EMR system, removed EMR note in "Records" section as it was moved to #8, in "Acronym" section removed "AAM", "DD", "MI", & "QI" and added "PCP".
C	10/14/15	Bulletized "Information" section and moved #1 from "Procedure" section to 3rd bullet, removed progress note form # (90-1008) and added "in EMR" (3 places), removed #8 which stated "Effective 1001/07, all progress notes are to be documented in EMR", corrected numbering errors, made numerous other grammatical corrections/changes without changing sentence content.
D	07/25/17	In 3rd bullet in "Information" section changed "There are two types of billable contacts, direct and support" to "There are two types of progress notes, direct and support (support progress notes are not billable)", made several additional minor wording/grammatical changes/corrections throughout document without changing sentence content.
E	04/03/19	In "Scope" section changed "contractual providers" to "contractual clinical provides", changed "PCP" to "IPOS" throughout document (4 places), in "Acronyms" section added "IPOS", made several minor wording/grammatical changes/correction throughout document without changing sentence content.
F	07/30/19	In "Information" section second bullet added first sentence and added "Clinical staff" & "typically", added third bullet.