## Chapter 9: The Early Intervention Record

### The Early Intervention Record

Local Lead Agency Responsibilities:

1. Maintain each child's early intervention record at the local lead agency or the local agency that houses the system's service coordinators. It is acceptable to have early intervention records located at satellite offices of the local lead agency or service coordinators' agency (e.g., if the local lead agency is the CSB and the CSB has offices in multiple cities or counties in the catchment area, then records may be kept at any of those CSB offices) as long as there is easy access to the records by local lead agency administrators for billing and supervision purposes.
2. Make children's early intervention records available to the State Lead Agency, the Department of Behavioral Health and Developmental Services, upon request and at the location designated by the State Lead Agency.
3. Ensure that each child's one early intervention record includes the following:
    a. Accurate demographic and referral information
    b. Signed releases and consents
    c. Other completed procedural safeguards forms
    d. Completed and signed Initial Early Intervention Service Coordination Plan, if child is new to the Infant & Toddler Connection of Virginia and has Medicaid/FAMIS
    e. Screening and assessment reports
    f. Medical reports
    g. All other documentation collected during eligibility determination and IFSP development including reports from previous outside screenings, assessments, etc.
    h. Completed Eligibility Determination form
    i. All IFSPs developed – current and past, including documentation of periodic reviews
    j. Contact logs or contact notes submitted by providers, including service coordinators
    k. Copies of all correspondence to and from the local Infant & Toddler Connection system or its providers with or on behalf of the family
    l. Court orders related to service provision, custody issues, and/or parental rights
    m. Signed *Family Cost Share Agreement* form, unless it is kept in a separate financial file – If the agreement form is filed in the early intervention record, it is recommended, but not required, that there be a separate section for financial information within the record, particularly for any information stored that documents the family's income or expenses.

n. Record Access log

Early Intervention Provider (Including Service Coordinator) Responsibilities:

1. Maintain a clinical/working file that must include, at a minimum, a copy of the IFSP (including reviews), contact notes, and any completed screening and/or assessment protocols if not housed in the early intervention record. Providers working in the agency where the early intervention record is housed have the option to maintain the items listed above in the early intervention record instead of in a separate clinical/working file.
2. Make contact notes available to the State Lead Agency or local lead agency upon request.

Contact Notes

The term "contact note" will be used in discussing below how Part C early intervention 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." Local Infant & Toddler Connection systems and early intervention providers are not required to call their documentation contact notes.

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

1. A chronological record of the child's and family's participation in the Infant & Toddler Connection 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:
    a. Provide an objective basis to determine the appropriateness, effectiveness and necessity of intervention, and
    b. Assist the IFSP team in assessment and service planning at IFSP reviews and annual IFSPs.
2. A means for communication among service providers and with the family.
    a. 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 or when the former provider is no longer providing services to that child and family.
    b. Under Part C, parents have the right to review their child's record.
3. Billing documents.
    a. Contact notes are used for billing purposes and must provide the information required by DMAS and other third-party payors.
4. Monitoring documents.
    a. Contact notes are reviewed by local system managers, program managers, State Infant & Toddler Connection of Virginia personnel, and DMAS 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.
5. Legal documents.

a. 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. 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.

General Rules for Contact Notes:

1. 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, consultations between providers related to the child and family but not with the child and family, 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.
    a. If two or more providers participate in the same treatment session, then they may each write a separate note documenting their time and activities or there may be one note to document the team treatment as long as that note clearly documents each provider's time and how each participated in the session. If a joint note is written, it must be signed by each provider. The option to write a joint contact note does not apply if <u>separate</u> sessions (e.g. at two different times) by two different providers occur on the same day.
    b. If one provider is performing two roles during a single visit (e.g., one provider is delivering service coordination and developmental services), then that provider may write one note specifying the amount of time spent and activities completed in each role.
    c. If one provider participated in two different activities on the same day (e.g., assessment for service planning and the IFSP meeting), then that provider may write one note specifying the amount of time spent and his/her role in each activity (assessment and IFSP meeting). It is acceptable to refer in the note to the IFSP for the specifics about assessment information and IFSP decisions made rather than repeating that information in the note.
    d. If there is communication related to a child who has been discharged from the local system, then such communication would require a contact note, which must be filed in the child's early intervention record.
    e. 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, then that contact must be documented in a contact note, which is then filed in the child's early intervention record.

<u>Do I Need to Write a Contact Note?</u>

- To document my participation in an assessment or an IFSP or IFSP review meeting, time spent (in minutes), and method of participation? **Yes**
- To document provision of procedural safeguards? **Yes**
- To document what services are planned? **No**, Section V of the IFSP is

sufficient documentation of planned services.

Not sure if you need to write a note? It's better to go ahead and write one!

2. Use contact notes to provide essential information that is not contained in meeting record forms such as the IFSP.
    a. The service coordinator must complete a contact note following the IFSP meeting to document the following:
        - The length of the IFSP or IFSP review meeting in minutes unless this is documented on the IFSP/IFSP review form. Since providers are billing for these services, the time spent must be clearly documented.
        - Any supports and services recommended by the team but not accepted by the family.
        - Instances where the family opted for a frequency, length, intensity (individual/group), or method of service that was different than what was proposed by other team members.
        - Justification for any frequency with multiple visits planned over more than a one-month period (10x/6 months), including why the frequency was chosen and the need for flexibility for this specific child and family.
        - Any other areas of disagreement among team members, including the resolution reached or, if the issue was not resolved, the plan for addressing the area of disagreement; and the rationale for planning a later start date for services, when applicable.
3. 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.
4. Document the reason for any difference in the frequency, length, intensity or location of a service provided compared to what is listed on the signed IFSP.
5. When the frequency planned on the IFSP is for multiple visits over a period of more than one month (e.g., 10x/6 months):
    a. Document justification if the maximum number of services planned over that period were not delivered
    b. For each visit, document discussion with the family about when the provider will come next and why
    c. Document discussions with the family and other providers to ensure the planned frequency remains appropriate based on child and family priorities and concerns.
6. Document that native language requirements have been met if the native language is other than English.
7. Write legibly.
8. Use the provider agency's rules regarding ink color for contact notes. Generally, black ink is preferred since it works best for faxing and copying.
9. Provide complete and accurate information about the contact or activity, ensuring that a third party could read the contact note and understand what occurred.

10. Record events and observations in a factual, non-judgmental way and avoid subjective comments.
11. Use positive statements.
12. Use language understood by all team members, including the family. Avoid jargon and abbreviations or explain them in the note.
13. Complete contact notes in a timely manner, no more than 5 business days from the time of the contact.
    a. Day 1 of the 5-business-day timeline is the day the service was provided/contact was made.
    b. The 5-business-day timeline applies only to having the note written and does not require that the contact note be placed into the child's early intervention record within that same period of time.
    c. If a handwritten note (that is to be transcribed into the electronic health record) is completed within five business days that meets the requirement even if the note is not entered electronically until after the 5-business-day deadline.

    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.
14. Correct errors on handwritten contact notes by drawing a <u>single line</u> through the incorrect information, providing the date of the correction and the initials of the reviser, then adding the correct information. Correct errors in electronic documentation by following agency requirements or 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 Contact Notes:

**For all contact notes** -

1. Child's first and last names – If there is more than one contact note on a page, 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).
2. Type of service provided (physical therapy, developmental services, service coordination, etc.)
3. Type of contact (phone, face-to-face, e-mail, etc.)
4. 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."). If a contact note is handwritten on one day and later typed or entered into an electronic record the date of the note would be the date it was handwritten.
5. Provider signature (with at least first initial and last name), discipline and credentials of provider and the date the note is signed by the provider. The signature of the provider must be handwritten or electronic; no stamps allowed. If a student participates in an assessment, meeting or services to a child (e.g., as part of a practicum or internship), then that student must sign the contact note along with the certified provider that was supervising the student.

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

1. A **narrative** description of what occurred during the session including what the provider did, what the family/caregiver did, how the child responded during the session (including what the child was able to do in relation to IFSP outcomes, goals, etc.), and suggestions provided to the family/caregiver for strategies to incorporate in the child's daily routines and activities. A contact note formatted as a check-off list does not provide the level of information required to know what occurred during the session.
2. Who was present
3. Length of session (in minutes)
4. Location/setting (e.g., home, day care, etc.) in which the service was provided
5. 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…."]
6. Plan for next contact.

**For contact notes documenting contact or other activities completed by the service coordinator, also include the following:**

1. The service coordination short-term goal that the contact activity is addressing and progress toward achieving the service coordination goal. Many of the supports that service coordinators provide to families are not specifically listed as goals on the IFSP. These generally fall under the second service coordination goal in Section IV of the IFSP, "Provide support and assistance to your family in addressing issues or concerns that emerge over time." The examples in the text box on the following page include ways to document how contacts address service coordination goals on the IFSP.
2. Length of time (in minutes) for the contact or other activity completed by the service coordinator. This applies to all contacts made with or on behalf of the family and can be recorded as the total time spent or by recording the start time and end time for the activity.

A contact note checklist is provided at the end of this chapter.

Additional Documentation Requirements Associated with Early Intervention Targeted Case Management (EI TCM)

1. Document the family's preferred method of contact (face to face, phone, email or text) for the family contacts that are required every three months. This can be documented in the contact note for the intake visit.
2. If the family's preferred method of contact is email or text, then there are three options for documenting the email or text communication that occurs:
    a. Place a copy of the email or text communication in the child's record;
    b. Copy and paste the content of the email communication into the contact note; or
    c. Summarize the content of the email or text communication in a contact note (as you would for a phone contact).

**Service Coordinator Contact Notes – Examples of statements for including Service Coordination (SC) Short-Term Goal addressed, progress toward goals:**

The following examples are not presented as complete contact notes. They give examples of statements within contact notes that meet the requirement to include what service coordination goal is being addressed and progress toward SC goals. The SC goals referenced in the four examples are those that are pre-printed in Section IV of the IFSP form and are shown in this box:

| | |
|---|---|
| Assist your family with the development and ongoing review and revision of the IFSP. | |
| Provide support and assistance to your family in addressing issues or concerns that emerge over time. | |
| Provide information and support your family, as needed, in accessing routine medical care for your child. | |
| Provide supports identified by your family to include resources for: | |

These examples illustrate *possible* ways to meet the requirement but not the only ways to meet the requirement.

- **Example One**: During today's visit, Mrs. Jones reported that she needs help with transportation to Jenny's medical appointment on 8/1/11 because her sister, who usually takes them to appointments, is not available this time. I assisted Mrs. Jones in contacting the Health Dept. to arrange for transportation that will be covered by Medicaid. (SC Goal 2)
- **Example Two**: Made a follow-up call to Mr. Smith to see if he had been able to get an appointment for James with one of the primary care doctors we discussed on 7/15/11. He reported that James has an appointment with Dr. Clark on 9/5/11. (SC Goal: Accessing routine medical care – progress made)
- **Example Three**: Development and ongoing review and revision of IFSP (SC Goal A) - Contacted Molly Miller, PT, and scheduled IFSP Review for Leigh Ann Mason for 7/29/11.
- **Example Four**: I talked with Mrs. Hopkins today about how the speech and language services are going. She responded that they are going well. She said that the therapist is teaching her new things to do with Janie and that Janie has started to say words to ask for what she wants and that they want to continue with the current frequency of early intervention visits for now. (SC Goal – assist family with ongoing review of IFSP).

In the contact note, you can refer to the short-term SC goal by a number (as in example one) or letter (as in example three) or by the full or shortened wording of that SC goal (as in examples two and four). You can add numbers or letters onto the IFSP form in Section IV by each goal as well if you feel that's helpful.

In addition, and depending on the individual needs of each child and family, you may also have added additional SC goals on the SC goal page. Any contact notes that addresses these goals would be referenced in the note as indicated above (by number, by letter or by using the full or shortened wording of that additional SC goal).

Finally, you may sometimes perform an activity that addresses more than one of the SC goals. If your activity and subsequent contact note includes more than one activity, you may identify both or all of the goals in your note as above by simply indicating more than one number, one letter, etc.

## Access to Records

The local lead agency may assume that the parent has the authority to inspect and review records relating to his or her child unless the agency has been advised that the parent does not have the authority under applicable Virginia law governing such matters as guardianship, separation, and divorce.

Local Lead Agency/Provider Responsibilities:

1. Identify one individual to assume responsibility for ensuring the confidentiality of any personally identifiable information;
2. Provide training or information on Part C confidentiality requirements (in accordance with the Family Educational Rights and Privacy Act, FERPA) to all individuals collecting or using personally identifiable information;
3. Provide parents, upon request, a list of the types and locations of records collected, maintained, or used for Part C by the local lead agency/provider.
4. Establish a procedure for parents or a representative of the parent to inspect and review the child's record(s) collected, maintained or used for Part C without unnecessary delay, before any meeting regarding an IFSP or any due process hearing, and in no case more than 10 days after the request has been made;
5. Keep a record using the *Access to Record* form of person(s), except parents and authorized employees, obtaining access to records collected, maintained or used by the local lead agency/provider, including the name of the person(s), date of access and purpose of access;
6. Respond to a parent request to amend information considered to be inaccurate or misleading or which violates the privacy or other rights of the child or parent by:
    a. Amending the information in accordance with the request within a reasonable period of time of receipt of the request; or
    b. Informing the parent of the local lead agency's refusal to make the requested amendments and advising the parent of their right to a hearing, as described in the *Notice of Child and Family Rights and Safeguards in the Infant and Toddler Connection of Virginia Part C Early Intervention System*.
7. Make available to parents an initial copy of the child's record at no cost to the family. After making available one copy of the record, the local lead agency/provider may not charge a fee for copies of records if the fee would effectively prevent the parents from exercising their right to inspect and review those records.
8. Inform parents when personally identifiable information collected, maintained, or used is no longer needed to provide supports and services to the child and destroy the information at the request of the parents. Permanent records of the child's name, date of birth, parent contact information (including address and phone number), name of service coordinator(s) and other early intervention service providers, and exit date (including year and age upon exit and any programs entered into upon exiting) may be maintained.
9. Ensure the early intervention record is maintained for a minimum of 3 years following the child's discharge from the Infant & Toddler Connection system. Local lead agencies have the option to require records be maintained for a longer period. The 3-year time period ensures access to the records in case dispute resolution or due process proceedings requesting reimbursement of any kind occur after the child's discharge.

Service Coordinator Responsibilities:

1. During the intake visit, point out where information related to storing, accessing, and correcting records is included in the *Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share*. Remind parents of this information when reviewing the Notice of Child and Family Rights and Safeguards at other required points in the early intervention process.

## Contact Note Checklist

Remember: Document all contacts made and all activities completed with or on behalf of the child and family.

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
- ☐ Length of the session/contact/activity in minutes
- ☐ 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 (discipline and credentials)
- ☐ Date of provider signature (should be date the note was written)

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

- ☐ Who was present (including child)
- ☐ A narrative that includes the following:
  - ☐ Information from family/caregiver about what has happened since last session including progress on joint plan developed at previous session
  - ☐ Details of how the provider supported the family/caregiver in a routine or activity related to goals and outcomes; strategies practiced and child's response
    - ☐ Specific examples of how the family/caregiver participated in the session including strategies practiced with the child and the child's response
  - ☐ Ongoing Assessment: documentation of child's skills observed and/or reported by family/caregiver including:
    - ☐ Child's progress in relation to the IFSP outcomes/ short term goals
    - ☐ New functional skills (if any) in any of the three global outcome areas.
  - ☐ Documentation of joint planning for implementation of strategies and supports between visits during the family/caregiver daily routines and activities
  - ☐ Plan for next contact

**For service coordination contact note, must also include:**

- ☐ Short-term Service Coordination goal(s) that is being addressed; progress toward goal(s)

Other:

- ☐ Handwriting is legible
- ☐ 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 5 business days 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 following agency requirements or 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.

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