Implementing Collaborative Documentation

Compliant

Efficient

Outcome Focused & Person Centered

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Collaborative Documentation

What is Collaborative (Concurrent) Documentation?

- Collaborative Documentation sometimes referred to as Concurrent Documentation, is a process in which clinicians and clients collaborate in the documentation of the Assessment, Service Planning, and ongoing Client-Practitioner Interactions (Progress Notes).

- **The Client must be present and engaged in the process of documentation development.**

Collaborative Documentation

Appropriate for use:

- Assessment (Concurrent and Collaborative)
- Assessment Updates (Concurrent and Collaborative)
- Service Planning (Concurrent and Collaborative)
- Service Plan Updates/ Reviews (Concurrent and Collaborative)
- Progress Notes - Individual , Group, Community Based (Collaborative)

Collaborative Documentation - Benefits

You can collaboratively document well or poorly!

- CD can be done in a way that clients and families will like or in a way that makes them resentful.

- Collaborative Documentation will save time and create capacity – but – it can also
  - Improve client engagement and client involvement
  - Improve compliance
  - Support person centered/driven services
  - Help focus clinical work on outcomes
  - Improve quality of work-life for staff

Collaborative Documentation

Collaborative Documentation Needed to Support:

- Timely communication with other providers (e.g. treatment team, integrated physical health partners, etc.)
- Care coordination and risk management
- True "informed consent" for sharing of information
- Documentation Transparency
- Increased clinical capacity needed for:
  - Rising productivity standards
  - Open/ Same Day Access
  - Centralized Scheduling
  - No show/cancellations and backfill management

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Collaborative Documentation:

Service Capacity and Productivity

Questions:

- What are your Direct Service Productivity Standards?
- National standards are moving to 65 – 70 % of "total paid time"
- Does this seem achievable?
- Is it easy?

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Productivity vs. Capacity

The Right Question to Ask!

As a Service Provider how much time would you like to spend with clients as opposed to the other things you have to do ?

CD vs. Post Session Documentation

Time Savings

- Transitioning from Post Session Documentation Model to Collaborative Documentation Model can save from 5 – 8 hours per week for full time staff.

Compliance And Service Quality

"If we actually meet the key elements of documentation compliance standards our clients will receive much better care!

Collaborative Documentation Supports Sustainable Compliance!

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Compliance

The Big Three

- Medical Necessity
- Client Participation
- Client Benefit

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Audit Environment and Risk Recovery Audit Contractors

ACTION: Final rule. Medicaid Program; Recovery Audit Contractors (RAC)

57808 Federal Register/Vol. 76, No. 180/Friday, September 16, 2011/Rules & Regulations
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
42 CFR Part 455 [CMS–6034–F]
RIN 0938–AQ19
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

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How much money are Medicaid RACs expected to recover?

In the final RAC rule CMS estimated that Medicaid RACs would recover the following amounts:

- ESTIMATED SAVINGS IN MILLIONS - FY 2012-2016

Year	2012	2013	2014	2015	2016	2012-2016
Federal	$60	$190	$280	$330	$360	$1220
State	$50	$140	$200	$250	$270	$910
TOT	$110	$330	$480	$580	$630	$2130

Note: Medicare RAC audits collected $2.4 billion in 2012 and expectation is that Medicaid RAC audits will follow similar trend!

- See more at: http://www.medicaid-rac.com/medicaid-faq/#sthash.iFzckRDe.dpuf

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Medicaid RAC contractors only get paid if they recover dollars for Medicaid

RACs only collect fees on overpayments that are recovered and underpayments that are corrected (12%). In addition, RAC contractors must return any recoveries that are reversed after a provider appeal. This means that auditors are incentivized to pursue only those claims they can prove are inaccurate.

- See more at: http://www.medicaid-rac.com/medicaid-faq/#sthash.iFzckRDe.dpuf

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NM - Public Consulting Group (PCG) Audit Report Summary

Audit Findings

Each of the 15 providers audited through this process failed to meet compliance standards.

$36 million in overpayments have been identified, amounting to more than 14% of the dollars paid to these providers.

The most egregious claims that were audited were found to have a more than 25% error rate while the case files impacting individual health and safety were found to have a 57% error rate.

Provider	Randomly Sampled Claims % Non-Compliance	Randomly Sampled Claims Extrapolation - Lower Bound	Longitudinal Claims % Claims Failed	Longitudinal Claims $Value Claims Failed	Total Overpayment Amounts
Provider A	29.3%	$ 2,046,690.0	64.8%	$ 179,903	$2,226,593
Provider B	35.3%	$ 2,757,585.0	84.6%	$ 210,548	$2,968,133
Provider C	13.3%	$ 772,016.0	27.8%	$ 78,854	$850,870
Provider D	14.9%	$ 565,309.0	35.5%	$ 291,436	$856,745
Provider E	21.8%	$ 3,629,976.0	70.7%	$ 103,063	$3,733,039
Provider F	6.0%	$ 57,614.0	97.4%	$ 22,736	$80,350
Provider G	55.3%	$ 3,138,735.0	38.2%	$ 55,521	$3,194,256
Provider H	27.3%	$ 4,327,784.0	59.6%	$ 161,843	$4,489,627
Provider I	3.3%	$ 7,856.0	41.1%	$ 14,018	$21,874
Provider J	36.7%	$ 1,304,140.0	34.8%	$ 44,239	$1,348,379
Provider K	15.3%	$ 1,028,069.0	98.6%	$ 437,537	$1,465,606
Provider L	21.1%	$ 9,262,711.0	60.2%	$ 335,833	$9,598,544
Provider M	17.3%	$ 612,663.0	20.0%	$ 43,137	$655,800
Provider N	40.0%	$ 4,128,958.0	49.7%	$ 64,907	$4,193,865
Provider O	18.0%	$ 228,309.0	97.1%	$ 68,661	$296,970
Grand Total	**23.7%**	**$33,868,415**	**57.1%**	**$2,112,234**	**$35,980,649**

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NM - Public Consulting Group (PCG) Audit Report Summary

- Assessments (psychosocial/psychiatric evaluations) were not up to date (within last 12 months) to determine if the consumer continued to meet the need of the rendered service.
  - Incomplete critical information such as Five Axis diagnosis.
  - Substance abuse history was absent for most consumers with a dual-diagnosis of mental health and substance abuse.
- Treatment plans were not up-to-date and individualized per consumer. Updated treatment plans are necessary to determine any changes to goals/objectives in addition to progress or lack of progress by the consumer. Without continuously updated treatment plans, it is impossible to determine if the treatment interventions still meet the behavioral health needs of the consumer.
  - Goals/Objectives were not measurable and did not document achievable target dates based on the consumer's needs.
  - Service specific clinical interventions used to reach goals/objectives were absent.

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NM - Public Consulting Group (PCG) Audit Report Summary

Longitudinal File Review Findings

- Safety/Risk Assessments were not completed or updated for consumers who were assessed to have current or past suicidal ideations (SI), homicidal ideations (HI), self harm or domestic violence issues.
- Treatment plans were not up-to-date and individualized per consumer.
  - Plans contained the same goals/objectives for more than 12 months.
  - Potential overutilization of services without documented justification of the service related to extensive length of stay.
- Consumer Documentation *(Progress Notes)*
  - Documentation frequently did not describe the clinical interventions, progress or lack of progress toward goals, and next steps in treatment.
  - Progress notes did not contain a start and stop time or a duration that would enable a determination as to whether the billed time was accurate.
  - Billed units did not match the units documented on the progress notes.

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Did the NM Audits Teach us Anything New?

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Did the NM Audits Teach us Anything New?

No!

They taught us the same things again!!

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Did the NM Audits Teach us Anything New?

What We Know

1. Our sense of security based on state, county, and local payor audits is often illusory.
2. Trying to manage compliance strictly through documentation formats, checklists, and documentation rules has never worked. They are helpful but not the solution.
3. Documentation is completed by clinicians! Separating documentation from the clinical process removes it from their sphere of interest. Compliance efforts will be mechanical – not substantive or sustainable!

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Ubiquitous Documentation Challenges

I see one or more of the following in 80% or more of charts I review annually:

Assessments:

- No specific support for diagnoses
- Assessments identify diagnoses but not individualized treatment targets (needs)
- Assessments are not updated to reflect changes in assessed target needs

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Ubiquitous Documentation Challenges

I see one or more of the following in 80% or more of charts I review annually:

Treatment Plans:

- Goals not linked to Individually Assessed Target Needs
- Life/Recovery Goals confused with Behavioral Health Goals
- Objectives are not "Measurable or Observable Outcomes".
- Failure to indicate "Specific Interventions/Methods" intended to help achieve Gs and Os in Tx. Plans

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Ubiquitous Documentation Challenges

I see one or more of the following in 80% or more of charts I review annually:

Progress Notes:

- No Linkage to Specific Goals and Objectives
- No clear statement of the Intervention(s) provided
- No statement of Progress related to Tx Plan Objectives
- No recommendations/plans for next steps

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Common Organizational Challenges

1. Documentation viewed as "necessary evil" (for audits and billing support) as opposed to important to clinical process, care coordination, and risk management.
2. No clear understanding/operational definition or audit focus related to Documentation Linkage (Golden Thread)
3. No operational definition of "Assessed Target Needs"
4. No agreed upon definition of Tx Plan Goals and Objectives that are in line with Federal Definitions
5. Allow use of "Drop Down" Goals and Objectives that are not individualized

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Simple Question

Ask 10 clinician client pairs who have been working together for at least 6 months what the clients' specific current Goals and Objectives are.

I estimate that 20% or fewer will know!

Do you know what specific outcomes you are working on when you work with your primary care physician?

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How Collaborative Documentation Can Help!

- Collaborative Documentation integrates documentation into the clinical process
- Documentation becomes useful to the interests and values of clinicians
- Documentation becomes timely (real time) by default and so provides value for risk management, care coordination, and compliance.
- Because documentation is done with the consumer there is a focus on treatment plans (not just in office linkage to treatment plans)

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How Collaborative Documentation Can Help!

- In order to document progress with the consumer the treatment plan needs to make sense and have objectives (measurable or observable outcomes) that the consumer can relate to. Treatment Plans improve!
- Client participation in Treatment Plan Development and Services becomes real and not just a signature or check box.
- Interventions will naturally be stated in terms of the actual description of interventions provided (common sense terminology) and phrases like "helped client process past abuse" or "provided empathic listening" will disappear.

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Compliance
Medical Necessity and the Golden Thread

Assessment Data:

Diagnoses – Strengths – Personal Goals - Assessed Needs (BH Problems)

Service Plan Goals

Service Plan Objectives (Outcomes)

Interventions and Services

Interactions Directed by Service Plan-Recorded in Progress Notes

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Compliance
Documentation Timeliness and Accuracy

Questions:

- What are your documentation timeliness standards?
- What percent of your documentation meets your standards?

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Documentation <u>Timeliness</u> and Accuracy

- What you do is important!
- Other providers within you organization and increasingly outside your organization (e.g. physical healthcare partners) should have the benefit of your documentation!
- Important care coordination and risk management issue!
- We need to move to "real time" documentation availability (or as close as possible!)

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Documentation Timeliness and <u>Accuracy</u>

- Collaborative Documentation is an <u>accurate</u> representation of what went on in sessions with the client.
- As time passes documentation gets more vague, homogenous, and less helpful.

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Common Concerns of Clinical Staff About Collaborative Documentation

Clinical:

- "It's not fair to clients – they will resent doing paperwork!"
- It will interfere with the "Client - Therapist Relationship"
- "Collaborative documentation takes away from treatment."
- "There are no clinical benefits to completing the documents with clients, especially children, and individuals experiencing paranoia or delusions."

Practical:

- "There is no way to complete a progress note, treatment plan, or assessment with a client."
- "I need time to think about what I want to write before I complete a note."
- "You cannot complete documentation collaboratively during a crisis situation."

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Collaborative Documentation

"It Can't Happen Here!"

(*Terminal Uniqueness*)

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CD vs. Post Session Documentation

It's Not fair to Clients!

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Collaborative Documentation Pilot Client Survey Results

1. On a scale of 1 to 5, how helpful was it to you to have your provider review your note with you at the end of the session?	Percentages Total	Total %
1 Very Unhelpful	1035	4%
2 Not helpful	289	1%
3 Neither helpful nor not helpful	2086	9%
4 Helpful	7116	31%
5 Very Helpful	11930	52%
NA No Answer/No Opinion	566	2%
Total/Approval %:	23,022	94%
2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)?	**Total**	**Total %**
1 Very Uninvolved	537	2%
2 Not involved	217	1%
3 About the same	2987	14%
4 Involved	6279	28%
5 Very Involved	11436	52%
NA No Answer/No Opinion	629	3%
Total/Approval %:	22,085	96%

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Collaborative Documentation Pilot Client Survey Results

3. On a scale of 1 to 5, how well do you think your provider did in introducing and using this new system?	Total	Total %
1 Very Poorly	98	0%
2 Poorly	53	0%
3 Average	925	4%
4 Good	5382	24%
5 Very Good	15132	69%
NA No Answer/No Opinion	423	2%
Total/Approval %:	22,013	99%

4. On a scale of 1 to 3, in the future, would you want your provider to continue to review your note with you?	Total	Total %
1 No	1149	5%
2 Unsure	2514	12%
3 Yes	16422	77%
NA No Answer/No Opinion	1132	5%
	0	0%
	0	0%
Total/Approval %:	21,216	94%

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10 Center Access and Engagement Project
National Council for Community Behavioral Healthcare

1. **AtlantiCare Behavioral Health** - Egg Harbor Township, NJ
2. **Avita Community Partners** - Flowery Branch, GA
3. **Carlsbad Mental Health Center** – Carlsbad, NM
4. **Cascadia Behavioral Health** – Portland, OR
5. **Colorado West Regional Mental Health** – Glenwood Springs, CO
6. **Counseling Services of Eastern Arkansas** – Forest City, AR
7. **The H-Group, Inc. (Franklin-Williamson Human Services)** – West Frankfort, IL
8. **Northside Mental Health Center** – Tampa, FL
9. **Ozark Guidance Center** – Springdale, AR
10. **The Consortium, Inc.** – Philadelphia, PA

Presenter: David Lloyd, National Council Consultant

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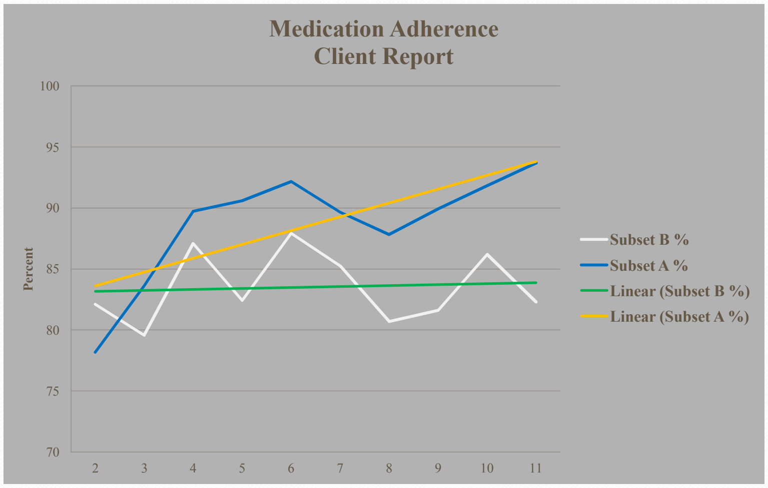
10 Center Access and Engagement Project
National Council for Community Behavioral Healthcare

Medication Adherence
Client Report



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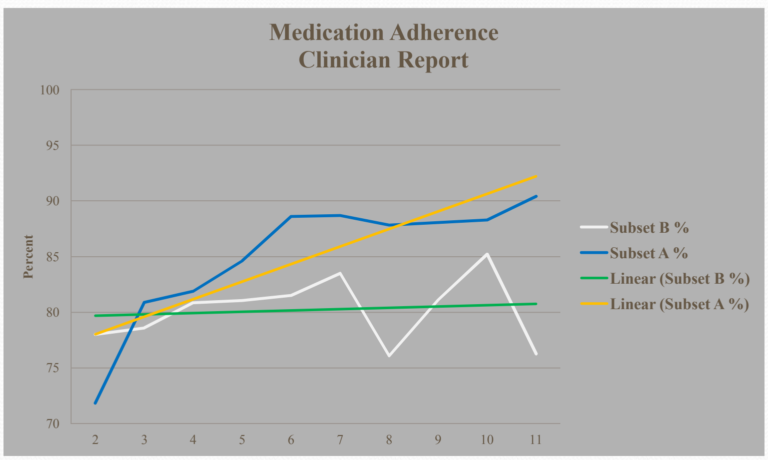
10 Center Access and Engagement Project
National Council for Community Behavioral Healthcare

Medication Adherence
Clinician Report



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The Evidence is in:
Doctors See Value in Sharing Visit Notes with Patients

Annals of Internal Medicine *10-2-2012*

The study shared findings from OpenNotes, a Robert Wood Johnson Foundation-supported initiative in which, over the course of one year, 105 doctors shared their notes with more than 19,000 patients at three health centers around the country—Beth Israel Deaconess Medical Center in Boston; Geisinger Health System in Danville, Pa.; and Harborview Medical Center in Seattle.

The study revealed that patients who participated in OpenNotes felt more in control of their health care, experienced improved recall of their care plan, and reported they were more likely to take their medications as prescribed. Doctors' fears about the added time burden and offending or worrying patients did not materialize, and many doctors reported that note-sharing strengthened their relationships with patients, including enhancing trust, transparency, communication, and shared decision-making.

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CD vs. Post Session Documentation

Quality of Work Life

- Collaborative Documentation eliminates:
  - Documentation treadmill (always catching up)
  - Hoping for No/Shows to complete paperwork
  - Separation of paper process from clinical process (irrelevance)

(VIDEO)

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Documentation Strategies That Support Collaborative Documentation

General Tips:

- Assume that your clients will read their documentation at some point.
- Agree to disagree when appropriate.
- Do as much as you can.
- Start with clients that you think will be receptive and who you are comfortable with. Then continue implementation from there.
- Start the process with new clients right away.

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Assessment

Questions:

- What is your standard appointment time for an Intake/ Assessment ?
- How much Post-Session time on average does it take to complete Intake/ Assessment ?
- Is there an opportunity to have non-clinical Intake Information completed by non-clinical staff prior to the Assessment session?
- How much flexibility do you have for modifying/ reformatting your intake/ assessment documents?

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Collaborative Documentation: **Intake/ Assessment**

Know your assessment instrument

- Take one content section at a time
  - Presenting Problem
  - Psychiatric Hx
  - Family Hx, etc….
- Discuss the section with the client/ family (take rough notes)
- Enter into System **allowing client to see and comment/clarify**
- Alternate between looking at the client and entering into computer.
- Point to computer screen to allow client to follow where you are and keep them feeling involved.

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Collaborative Documentation: **Intake/ Assessment**

Know your assessment instrument

Diagnoses:

- Good opportunity for psycho-edulation. Talk with client about what diagnoses really are and then share your current conclusions and document with client.

Interpretative/Clinical Summary

- Say "OK, let sum up what we've discussed". Document with the client.

Identified Needs/ Problems

- Say, "So the areas that we've identified that we should work on together are 1: ….. , 2:……, etc." If the client doesn't want to work on one or more of these record that with the client.

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Challenges:

Examples

- EHR Check boxes that contain technical terminology (e.g. Mental Status Section)
- Risk Assessment – Lethality
- Readiness for Change
- Above are all opportunities for psycho- education and discussion.
- "Agree to Disagree" and allow for documentation of client perspective in addition to clinician perspective.
- Many checkboxes can be completed without discussion particularly when they don't apply.
- May need to reserve some sections for after session.

Assessment

Setting the Stage for Treatment Planning

- Develop clearly identified and prioritized Behavioral Health Needs (Problem Areas) that can be used to establish Goals.
- Diagnoses alone don't provide an adequate basis for person centered treatment planning!

Examples of Identified Needs/ Challenges

- Symptoms
  - Mental Health
  - Substance Abuse
- Behaviors
- Functional/ Skill Deficits
- Supports Deficits
- Service Coordination Needs
- Other Identified Needs

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OSCRI Assessed Needs

Prioritized Assessed Needs: A-Active, ID-Individual Declined, D-Deferred, R-Referred Out	A	ID*	D*	R*
1.	☐	☐	☐	☐
2.	☐	☐	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐

***Individual Declined/Deferred/Referred Out-Provide Rationale(s)** (Explain why Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is Deferred/Referred Out below) ☐ None

1.

2.

3.

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Assessment

Setting the Stage for Treatment Planning

- Identify Personal Life / Recovery Goals when possible to help develop person centered goals.
- When possible establish **Baselines** ("as evidenced by") for Symptoms, Behaviors, Skill and Functional Deficits, etc. in order to develop objectives.

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Personal Life Goals

When You Ask the Question!

- "Be able to socialize and make friends"
- "Be able to live on my own"
- "Get my GED and work in medical transcription."
- "Take care of my kids & get back into church."
- "Spend time with my grandchildren unsupervised."
- "Going back to school and working."
- "To maintain positive relationship with parents and siblings."
- "Be able to talk to sister without getting upset or mad"
- "Stay out of the hospital"
- "Keep my apartment"

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Service Planning

Goals

Definition:
A Goal is a general statement of outcome **related to an identified need in the clinical assessment**.

A goal statement takes a particular identified need and answers the question, **"What do we (clinician and client) want the outcome of our work together to be, as we address this identified need?"**

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Service Planning

Examples of goals:

- "Elana states she wants to stop relapsing with alcohol and drugs
- "Jordan wants to get her energy and confidence back"
- "Ben's parents want him to stop getting into trouble in school and at home"
- "John states he just wants to feel normal and Quiet the Voices"
- "Gwen states she wants to learn how to take care of herself "

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Service Planning

Goals

- Incorporate personal goals when possible with behavioral health goals

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Service Planning

Examples of goals:

- "Elana states she wants to stop relapsing with alcohol and drugs so she can regain custody of her children."
- "Jordan wants to get her energy and confidence back so she can finish her education and have a social life again. "
- Maria states she wants enjoy doing things again and have her energy back so she have a social life again.
- "Ben wants to stop getting into trouble in school and at home so he can stop getting grounded and play school sports"
- "John states he just wants to feel normal and quiet the voices so he can get a job and have friends"
- "Gwen states she wants to learn how to take care of herself so she can live on her own"

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Service Planning

Objectives (Measurable or Observable Outcomes)

Definition:

Objectives are **observable or measurable outcomes**

- Positive changes in behavior, functioning, symptoms, information, skills, support level
- Or maintenance of an observable or measurable desired level of the above
- Related to achieving a goal and expected to result from a needed intervention(s).

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Service Planning

Think of Objectives as "milestones" not as things a client will do!

Three Kinds of Changes from Baseline:

1. Changes in Level of Understanding of an Identified Need
2. Changes in Competencies, Skills, Information
3. **Changes in Behaviors, Functioning, Symptoms, Conditions (e.g. level of Supports)**

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Service Planning

Examples of Objectives:

- "Steven and the clinician will understand the chief causes of Steven's Panic Attacks"
- "Jordan will be able to articulate and demonstrate 3 strategies for reducing symptoms of depression."
- **"Jordan will engage in productive and/or leisure activities with others outside her home at least twice a week."**
- "David will be able to identify the situations that make him frustrated/ angry in school and will be able to articulate and demonstrate 2 strategies for appropriately dealing with them.
- **"David will reduce verbally aggressive outbursts in class from 3 or more times daily to once or less weekly."**
- "Client's mother will learn and implement 3 key strategies for dealing with Jason's oppositional behaviors."
- **"John's will follow his mother's directions with only one follow-up prompt 70 percent of the time.**

Service Planning

Objectives

- Attempt to develop a measurable change that:
  - Will be apparent to the client
  - Meaningful to the client
  - Achievable in a reasonable amount of time
  - Can be assessed in an objective way

Measuring Objectives

- Some Objectives are easy to measure and for the client or family to report on.
  - Articulation and demonstration of skills/strategies
  - Demonstration of knowledge
- Some Objectives are better assessed with the use of self tracking tools or scales:
  - Symptoms
  - Behavioral changes
- You don't want to just be measuring the client's latest experience today or yesterday.

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Treatment Plans

Paradigm for Development of Objectives

Identify a reasonable change from baseline that you expect interventions to attain in 3 or 6 months

- ✓ ***Symptom(s):*** (e.g. change in PHQ9 score from …to..; change in nature and frequency, etc.)
- ✓ ***Functioning Level:*** (e.g. change in DLA20 overall or specific scale scores from … to …., or specific description of change)
- ✓ ***Behaviors:*** (e.g. Change in intensity and/or frequency "from…to")
- ✓ ***Competencies:*** (e.g. ability to identify several triggers, ability to articulate/ demonstrate coping skills, etc.)

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Service Planning

Interventions (Methods)

Definition:

An intervention is a clinical strategy or type of action that will be employed within a Service type (modality) and is expected to help achieve an Objective.

Interventions briefly describe what approach, strategy and/or actions the Treatment Plan is prescribing.

Service Planning

Examples of Interventions:

- "Help the client identify triggers for his anger and develop strategies to for avoiding these triggers or responding differently",
- "Provide education on the physical, emotional and other effects/consequences of substance use"
- "Use CBT to help client challenge destructive irrational beliefs that lead to feelings of guilt"
- "DBT" (When an intervention strategy is very well articulated, has defined fidelity steps, it may not be necessary to do more then indicate the type of intervention strategy with some key elements that are understandable to the client.)

Collaborative Documentation
Treatment (Service) Plan

Goals:

- Start with discussing previously identified current need/challenge areas
- Select one identified need/ challenge area and ask, "What do we want the outcome to be as we work on this issue? Discuss and enter a collaborative statement.
- Ask if we accomplished that what would you have or be able to do that you can't now? Add this personal goal to the goal statement

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Collaborative Documentation:
Treatment (Service) Plan

Objectives(Observable / Measurable Outcomes):

- For the identified goal identify one or two objectives with client that are changes in baseline in either level of understanding of and issue; competencies, skills, information; – OR – behaviors, symptoms, conditions. Document with client.

Interventions and Services

- Discuss the Intervention(s)/ Strategy that will be used to help achieve the objective. Document with the client.
- Indicate the modality/service that the intervention(s) will be provided in as well as the frequency and duration

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Progress Notes: Interventions/ Interactions

Importance of Service Plan Awareness !

- Be Aware of the Service Plan BEFORE the session and know what Goal(s) Objectives you plan to work on with client.
- Your plan may need to change but you should have a plan.
- Focusing on the Service Plan reinforces the value of the plan.
- If the plan becomes irrelevant – change it.

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Interventions/ Interactions

How are You Doing?

- When you ask "How are you doing?" people will generally answer the question "How is the world treating you"
- This can often move the focus of a session to a discussion of recent events, mini crises, etc. (meandering with the client)
- By preparing for interventions you can keep the focus on "How are you Doing?" (e.g. "How are you applying what you've learned to this new situation)
- This will focus the session and result in progress notes that link to the treatment plan

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Interaction/Progress Notes

1. New or pertinent information provided by client.
2. Changes in Mental Status
3. Goal(s) and Objective(s) (from <u>current</u> service plan) addressed
4. Describe the intervention provided (should be consistent with prescribed intervention(s) from Svc. plan.
5. Describe client's response to intervention
6. Describe client's overall progress re the goal/ objective being addressed
7. Describe the plan for continuing work

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New Issues / Stressors / Extraordinary Events Presented Today: ☐ New Issue Resolved, No Update Required
☐ New Issue, CA/IAP Update Required ☐ None Reported
Explanation:

Goal(s)/Objective(s) Addressed As Per Individualized Action Plan:

Goal	Goal	Goal	Goal
Objective ___ Objective ___ Objective ___ Objective ___	Objective ___ Objective ___ Objective ___ Objective ___	Objective ___ Objective ___ Objective ___ Objective ___	Objective ___ Objective ___ Objective ___ Objective ___

Intervention(s) / Method(s) Provided:

Response to Intervention / Progress Toward Goals and Objectives:

Plan / Additional Information (Indicate action plan between sessions/meetings):

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Collaborative Documentation: Progress Notes (therapy/ skill building)

- Interact normally with the client during session taking notes on pad saying "I'm going to jot down some notes so we'll remember them when we write our note at the end of the session".
- At end of session (Time usually used for "Wrap Up") say "Lets review and write down the important parts of our session today.

MTM Services

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Interaction/Progress Notes

1. New or pertinent information provided by client.
2. Changes in Mental Status
3. **G**oal(s) and Objective(s) (from current service plan) addressed
4. Describe the **I**ntervention provided (should be consistent with prescribed intervention(s) from Svc. plan.
5. Describe client's **R**esponse to intervention
6. Describe client's overall **P**rogress re the goal/ objective being addressed
7. Describe the **P**lan for continuing work

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Discussion - Service Scenarios

Office Based - Individual therapy

- Adults
- Children
- Family Therapy

- Group
- Community Based
  - Homes
  - Community Settings

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Questions and Discussion

Common Questions:

- What if a client says "I don't want to document during the session"?
- What if I have a different perspective than the client?
- What if a client says they don't want me to record something in their chart?
- How do I document something I don't want the client to see?
- What if a client is too cognitively impaired to participate in CD?
- How do you do collaborative documentation with children?

- Other Questions?

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Collaborative Documentation

Implementation

Collaborative Documentation

Keys to Successful Collaborative Documentation Implementation

- Attitude (clinician/ organization)
- Preparation
- CQI Approach

Concurrent Documentation

The 7% Percent Factor

- There are situations where concurrent documentation is not appropriate
- 93% of the time concurrent documentation is appropriate, positive and helpful.
- Failures to implement are often due to a focus on the 7%

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Clinician Attitude

- View collaborative documentation as an essential element of the therapeutic process that you are learning to integrate into and consistently use in all of your direct service sessions.
- If you project CD as an valuable interactive process your clients will perceive it this way also.
- Setting routine is one of the best ways to get into habit.
- Implementation experience shows that collaborative documentation will become a habit within 6 weeks.

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Implementing Collaborative Documentation

How to Make it Happen:

- **Technology Needed** - What technology is needed/available?
- **EHR** – Assess your EHR's support for CD
- **Office Setup** – Do you need to move computers, screens, office furniture?
- **Peer Support Pilot Program** – Identifying a group of staff to pilot CD and be leaders in transition.
- **Training** – Prepare pilot staff with the basic strategies
- **Scripts** – Know how you are going to explain the process to your clients before your session.
- **Do as much as you can** - Completing a portion of the note in session as you are starting out is okay; simply move to do more each time.
- **Clinical Judgment** - Collaborative documentation will not work with every client in every situation.

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Sample Office Setup

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Introductory Scripts

Sample Introductory Script for Existing Clients

"As you know I normally write notes about our sessions afterward in my office. We now believe that there is value in making sure that you contribute to what is written in your notes. Also, I want to be sure that what I write is correct and that we both understand what was important about our sessions."

"So from now on at the end of the session we will work together to write a summary of the important things we discuss"

Introductory Scripts

Sample Introductory Script for New Clients

"Here at (agency name) we believe that there's value in making sure that you contribute to what is written in the notes about our sessions with you. Also, I want to be sure that what I write is correct and that we both understand what was important about our sessions."

"So at the end of the session we will work together to write a summary of the important things we discuss"

Mid Western Colorado: Concurrent Documentation Guidelines

Transitioning to CD In the session

- Use the traditional "wrap up" at the end of the session to try and transition to the documentation. This is something that many clinicians are used to doing as they try to synthesize what was done during the session and bring some closure to the process. You might say "We're getting close to the end of the session. Let's stop here and review what we talked about." The only difference is that instead of just doing a verbal recap we write it down on paper or it's done directly on the computer ECR.

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Concurrent Documentation

- Implementing a Pilot
  - Select pilot "Volunteers"
  - Collect baseline documentation time data (Optional)
  - Train
  - Pilot process
  - Collect client and clinician feedback
  - Debrief Pilot Staff as a Group
  - Address Barriers
  - Kickoff Organization-wide
  - Supervise/Coach

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Questions / Discussion

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