Worthwhile Collaborative Documentation

Support for Engagement, Person Directed Outcome Focus, Improved Capacity , and Compliance

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Demonstrating Our Value

As we make organizational and process changes necessary to accommodate the need for faster access and more efficient services …

…we must to remember that our "Value" to clients and to payers under healthcare reform will be measured by our ability to produce "Positive Outcomes" and reduce the use of unnecessary disruptive and high cost services!

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What Do We Do?

Our Mission is Not to Care About Our Clients!

That's something we need to do to accomplish our mission…

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What Do We Do?
Our Mission is Not to See Lots of Clients!
That's something we need to do
to stay viable…
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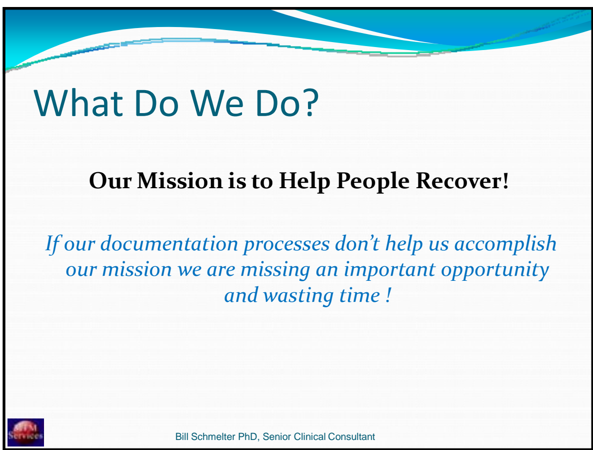
What Do We Do?
Our Mission is to Help People Recover!
If our documentation processes don't help us accomplish
our mission we are missing an important opportunity
and wasting time !
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Integrating Clinical Practice and Clinical Documentation

- Documentation has Become "The ENEMY"
- Clinicians report that documentation competes with time spent with clients
- Count on "no-shows" to complete paperwork
- Clinician's "Paper Life" is divorced from their "Clinical Life"

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Compliance and Quality

Compliance Focus

- "Compliant Looking Paper" ?
- "Quality Service Processes" that meet the "Spirit of Standards" ?

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Compliance and Quality

When We Focus on Paper Compliance

Clinical Staff come to not just devalue documentation but also to de-value the clinical processes they represent:

- The Assessment Process
- The Service Planning Process
- The Value of the Service Plan for their Work with Clients

Don't let the Compliance "Tail" Wag the Quality "Dog"

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Collaborative Documentation

What is Collaborative Documentation?

- Collaborative Documentation is a process in which clinicians and clients collaborate in the documentation of the Assessment, Service Plan, and Progress Notes.
- CD is a clinical tool that provides clients with the opportunity to provide their input and perspective on services and progress, and allows clients and clinicians to clarify their understanding of important issues and focus on outcomes.
- The Client must be present and engaged in the process of documentation development.

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Collaborative Documentation:

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

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Collaborative Documentation

Effective for use in:

- Assessment
- Assessment Update
- Service Planning
- Service Plan Update
- Progress Notes – Office Based or in Community
- Individual, Family, & Group

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Collaborative Documentation & Service Capacity

Productivity:

The right question to ask:

"As a service provider what percentage of your time would you like to spend with clients as opposed to the other things you have to do?"

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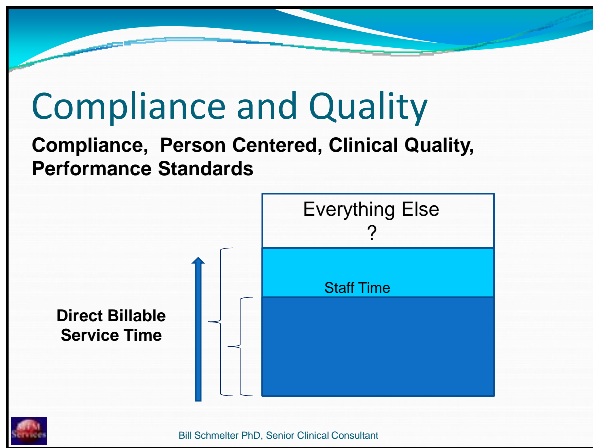

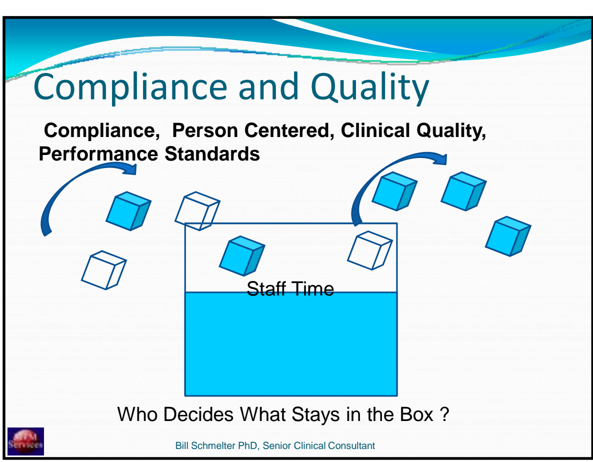

Collaborative Documentation

Collaborative Documentation takes a significant amount of documentation time out of the box …

And

Improves compliance and service quality!

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CD vs. Post Session Documentation

Time Savings

- Project outcomes demonstrate that transitioning from Post Session Documentation Model to Collaborative Documentation Model can save from 6 – 9 hours per week for full time staff

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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)

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Compliance

The Big Three

- Medical Necessity
- Client Participation (Person Driven Services)
- Client Benefit

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Medical Necessity

Medical Necessity Phase 1:

- Establish that an individual seeking behavioral health services is qualified to receive specific services at a particular level of care and/or intensity.
  - Qualifying DSM-IV diagnosis of a mental, behavioral, or emotional disorder
  - Diagnosed within the past year by a qualified practitioner
  - Results in functional impairment which substantially interferes with or limits the person's daily life activities.

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Medical Necessity

Medical Necessity Phase 2:

- Establish that <u>all services and interventions</u> provided are necessary and potentially sufficient to:
  - Address assessed needs in the areas of symptoms, behaviors, functional deficits, and/or other deficits/ barriers directly related to or resulting from the diagnosed behavioral health disorder
  - Produce improvements or prevent worsening

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Medical Necessity

- **Decide if you'd pay for that!**
  - Every Progress Note is a bill for services.
  - Would you pay for what you read in a progress note?
  - We get paid to provide skilled interventions that address assessed BH needs and help a person reach personal life goals .
  - We don't get paid for conversations that meander with the client or focus on the 'mini crisis' of the day.

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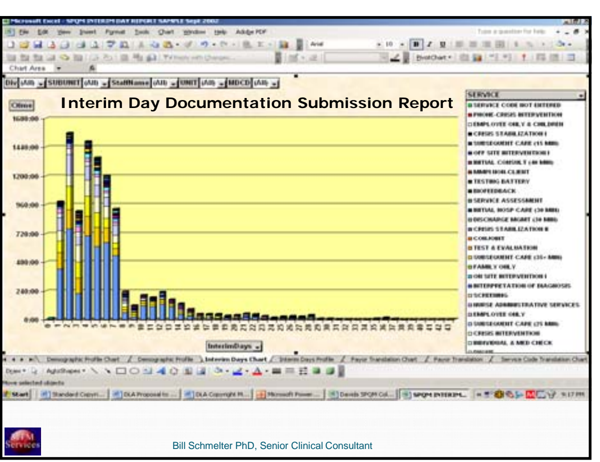

Person Centered Services

Person Centered Services :

- Focus on the person / family in the context of their personal/ life goals , individual strengths, unique barriers, etc.

Person Driven Services:

- Involving the individual/ family in directing the plan of care (developing, reviewing, updating service planning)

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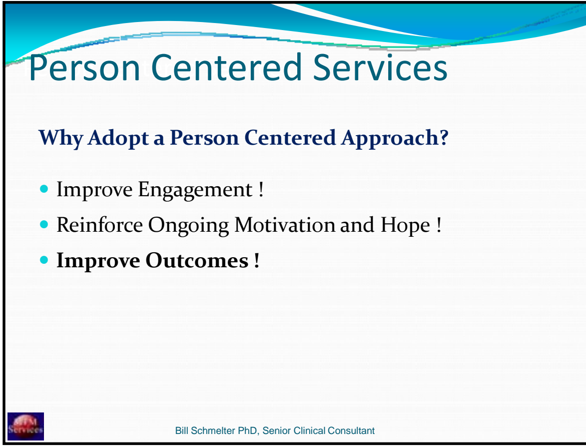

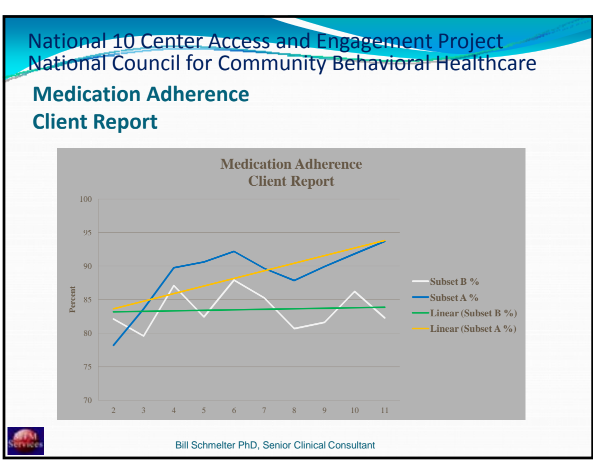

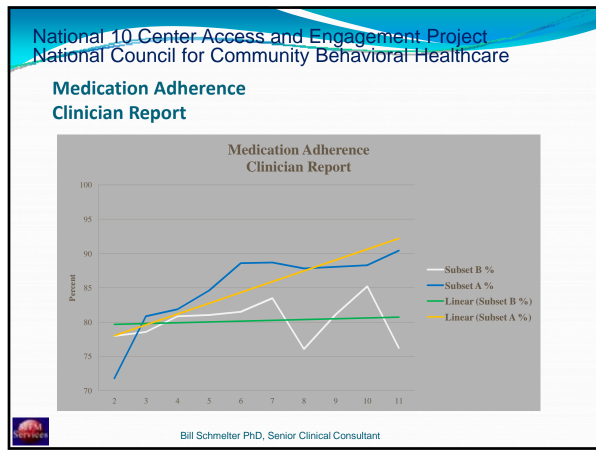

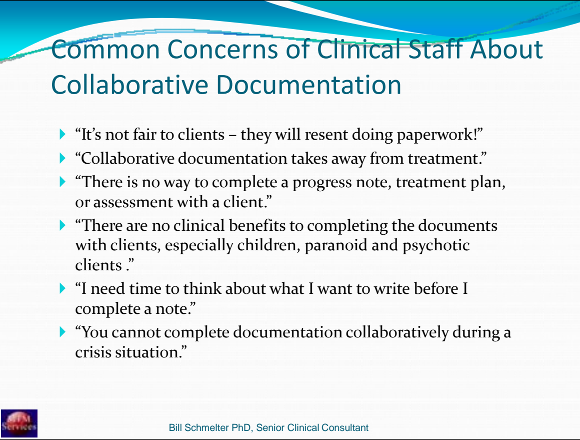

Collaborative Documentation

"It Can't Happen Here!"

(*Terminal Uniqueness*)

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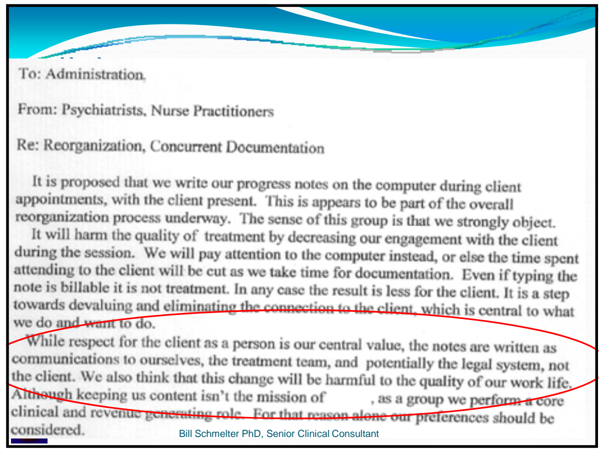

To: Administration,

From: Psychiatrists, Nurse Practitioners

Re: Reorganization, Concurrent Documentation

It is proposed that we write our progress notes on the computer during client appointments, with the client present. This is appears to be part of the overall reorganization process underway. The sense of this group is that we strongly object.
It will harm the quality of treatment by decreasing our engagement with the client during the session. We will pay attention to the computer instead, or else the time spent attending to the client will be cut as we take time for documentation. Even if typing the note is billable it is not treatment. In any case the result is less for the client. It is a step towards devaluing and eliminating the connection to the client, which is central to what we do and want to do.
While respect for the client as a person is our central value, the notes are written as communications to ourselves, the treatment team, and potentially the legal system, not the client. We also think that this change will be harmful to the quality of our work life. Although keeping us content isn't the mission of , as a group we perform a core clinical and revenue generating role. For that reason alone our preferences should be considered.

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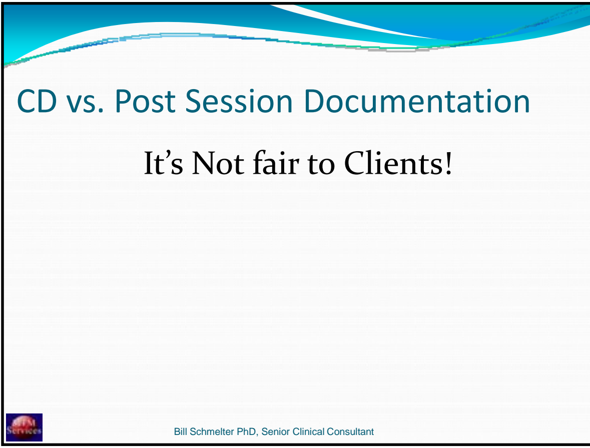
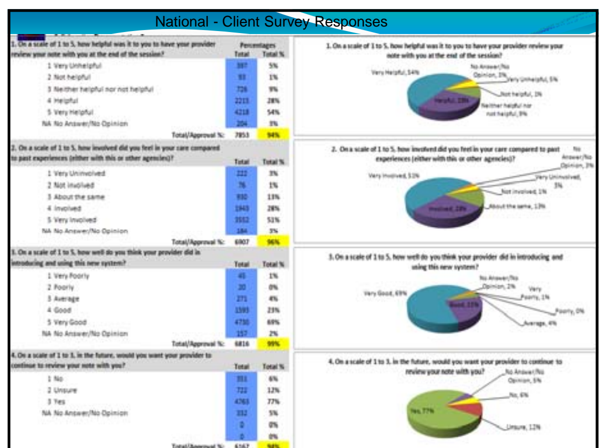




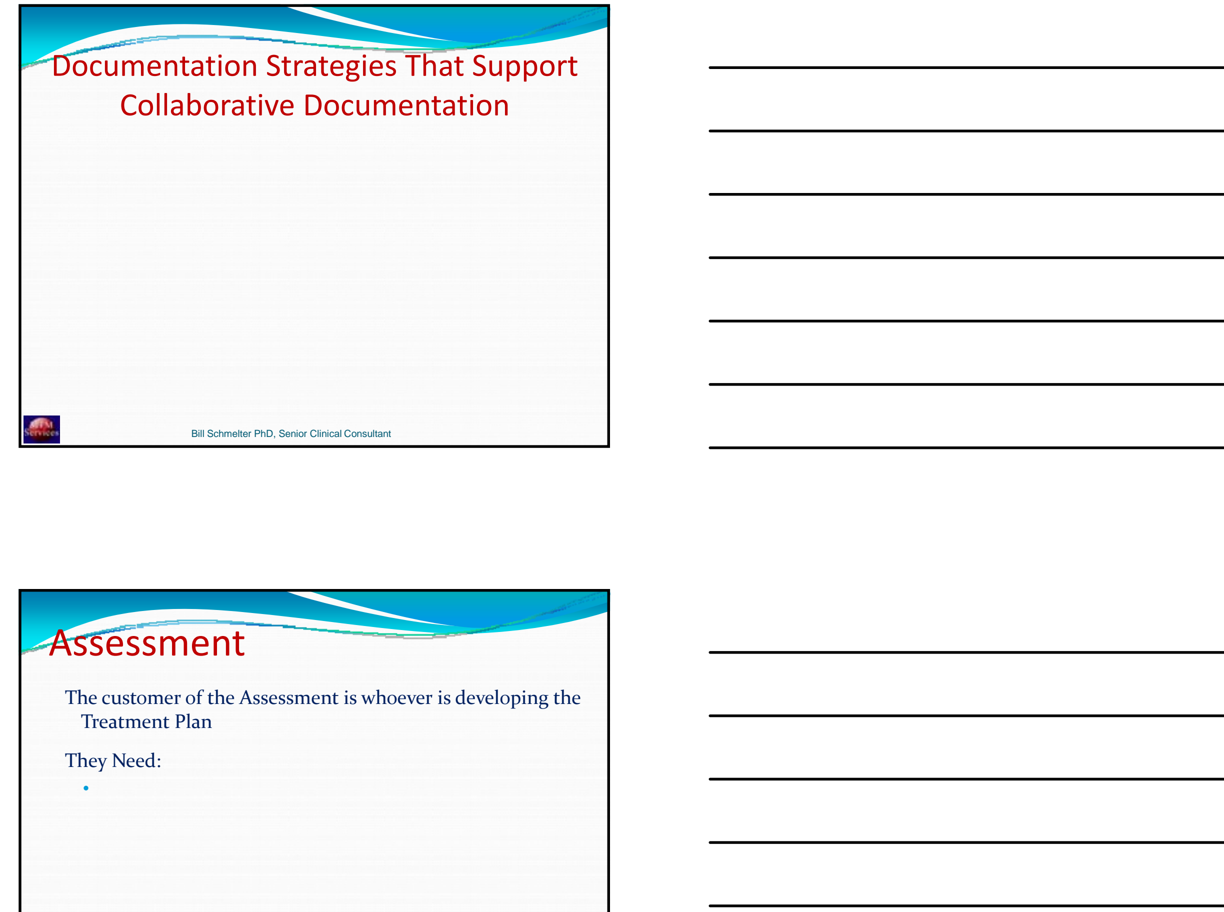
National - Client Survey Responses

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?	Total	Total %
1 Very Unhelpful	397	5%
2 Not helpful	93	1%
3 Neither helpful nor not helpful	726	9%
4 Helpful	2215	28%
5 Very Helpful	4218	54%
NA No Answer/No Opinion	204	3%
Total/Approval %:	7853	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	222	3%
2 Not involved	76	1%
3 About the same	930	13%
4 Involved	1943	28%
5 Very Involved	3552	51%
NA No Answer/No Opinion	184	3%
Total/Approval %:	6907	96%

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	45	1%
2 Poorly	20	0%
3 Average	271	4%
4 Good	1593	23%
5 Very Good	4730	69%
NA No Answer/No Opinion	157	2%
Total/Approval %:	6816	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	351	6%
2 Unsure	722	12%
3 Yes	4763	77%
NA No Answer/No Opinion	332	5%
	0	0%
	0	0%
Total/Approval %:	6167	94%


Documentation Strategies That Support Collaborative Documentation
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Assessment
The customer of the Assessment is whoever is developing the Treatment Plan
They Need:
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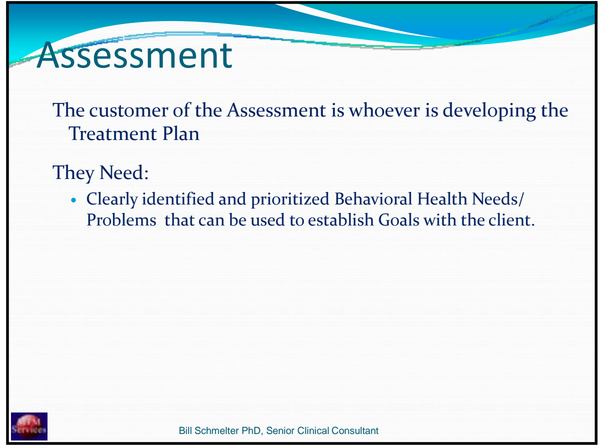
Assessment
The customer of the Assessment is whoever is developing the Treatment Plan
They Need:
Clearly identified and prioritized Behavioral Health Needs/ Problems that can be used to establish Goals with the client.
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Prioritized Assessed Needs: A-Active, 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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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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Assessment

The customer of the Assessment is whoever is developing the Treatment Plan

They Need:

- Clearly identified and prioritized Behavioral Health Need/ Challenge areas that can be used to establish Goals
- Symptoms, Behaviors, Skill and Functional Deficits stated as 'baselines' whenever possible in order to develop objectives.

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Assessment

The customer of the Assessment is whoever is developing the Treatment Plan

They Need:

- Clearly identified and prioritized Behavioral Health Need/ Challenge areas that can be used to establish Goals
- Symptoms, Behaviors, Skill and Functional Deficits stated as 'baselines' whenever possible in order to develop objectives.
- Client Strengths , Preferences , and Personal/ Life Goals that will be useful in developing service plan Gs and Os and in supporting change

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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
- Enter into System allowing client to see and comment/clarify

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Collaborative Documentation: Intake/ Assessment

Diagnoses:

- 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/ Challenges

- 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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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"
- "Ben wants to stop getting into trouble in school and at home"
- "We want Chris to be able to calm down and focus 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 and live on her own"
- "Jordan wants to get her energy and confidence back"

For an involuntary/ non-engaged client.

- "Robert will recognize the negative effects Substance Use is having on his life and voluntary participate in recovery services"

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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."
- "Ben wants to stop getting into trouble in school and at home so he can stop getting grounded and play school sports"
- "We want Chris to be able to calm down and focus in school and at home so he can do well in school and things can calm down at home.
- "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"
- "Jordan wants to get her energy and confidence back so she can finish her education"

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Service Planning

Objectives (Observable or measurable outcomes)

Definition:

- Objectives are observable, measurable, changes in behavior, functioning, symptoms, skills, support level.etc that relate to achievement of the goal, and are expected to result from planned interventions.
- The Assessment should identify the baseline levels of symptoms, functional/ skill deficits and behaviors that constitute the basis for the identified needs. Objectives are stated changes in these baselines.

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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 outside the 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."
- **"Jason will follow his mother's directions with only one follow-up prompt 70 percent of the time.**

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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 a nonjudgmental way
- Discuss the relationship of the desired change to achieving the behavioral health goal and personal life goal(s)

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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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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 to the goal statement

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Collaborative Documentation: Treatment (Service) Plan

Objectives:

- 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 current 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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Collaborative Documentation:
Progress Notes (Therapy Sessions)

- 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.

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Collaborative Documentation: Progress Notes

Separate the discussion into brief talking points:

1. New salient information provided by client.
2. Changes in Mental Status
3. Goal(s) and Objective(s) that were focused on
4. Interventions (what did we do to help reach the objective)
5. Client's response to intervention (today)
6. Client's progress re the Goal/ objective being addressed
7. Plan for continuing work

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Collaborative Documentation

Implementation

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Collaborative Documentation

Keys to Successful Collaborative Documentation Implementation

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

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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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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?
- **Training** – Prepare pilot staff with the basic strategies
- **Scripts** – Know how you are going to explain the process to your clients before your session.
- **Peer Support Pilot Program** – Identifying a group of staff to pilot CD and be leaders in transition.
- **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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Collaborative Documentation Setup

- **Script Elements** –
  - This is your note/chart
  - This is your care
  - Writing the note now will help us ensure a higher quality note that better represents your progress
  - Your opinions and feedback are very important in the development and maintenance of your treatment goals
  - We want to make each service the best for you that we can
  - We will only take notes during the last few minutes of your session

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Collaborative Documentation

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"

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Collaborative Documentation

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"

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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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Discussion - Service Scenarios

- Office Based - Individual therapy
  - Adults, Adolescents, Children
  - Family Therapy
- Group
- Community Based
  - Homes
  - Schools
  - 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?

- Other Questions?

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Pilot

- Generally 6 weeks
- Pilot is not to see if Collaborative Documentation works but to identify organizational / programmatic challenges so they can be addressed.
- Pilot staff can then be used as supports as you roll out Collaborative Documentation organization-wide.
- Administer "Client and Staff Collaborative Documentation Response Surveys" .

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