Collaborative Documentation: How to streamline chart documentation and include clients’ in the process

Rebecca Liben Levy and Benjamin Clemens
April 26th, 2017
Objectives for Today

- Describe the collaborative documentation model.
- Demonstrate how collaborative documentation results in better notes, and better treatment.
  - Assessments
  - Treatment Plans
  - Progress Notes
What is collaborative documentation?

*Collaborative (or concurrent) documentation* is a practice where clinician and patient document together, during the session.

- Concurrently for assessments/treatment plans
- Beginning and end for psychotherapy sessions
  - “first five and last five”
Use patient-friendly language – or the patient’s own words whenever possible

“Patient is experiencing visual hallucinations”

“Patient states she sees purple people in her room at night”
Collaborative Documentation

- Ask clarifying questions and agree with the patient about what’s written into their chart – this helps engage them in the process so the computer is not an intrusion
  - “You said the anxiety is worse, and you had several panic attacks this week. Is that right?”
  - “Our plan, then, is to meet again in two weeks?”
Collaborative Documentation

- Let the patient ask questions!
  - They may not understand what something in their chart means
  - Great opportunity for psycho-education
Why do we use collaborative documentation?

- Improves clinician quality of life:
  - Avoid the chronic, “never caught up” model
  - Can leave work at work!
  - Higher staff morale, less “burnout” and clinicians feeling overwhelmed/anxious
Improved clinical care/outcomes:
- Improved engagement – patients are excited about their treatment and more “empowered”!
- More focus on treatment plan and goal achievement
- Decrease length of treatment episodes
- Complements use of solution-focused, evidence-based models
- Patients get better!
Benefits, cont.

- Improves compliance:
  - Documentation is more likely to be complete and of high quality when on time
  - Helps to ensure documentation of clinical necessity, and prompts clinicians to link progress notes to treatment plan goals, etc.
  - No billing before documentation is in a place
Continued

- Improves individual and center productivity and service capacity:
  - Gives clinicians incentive to improve no-show rates (average of 15% reduction)
  - More appointments available equals more patients can be seen
  - Clinic can be financially sustainable
Client Satisfaction

Case Study: Health Center in Massachusetts (2009)

Of 927 respondents whose clinician used the concurrent documentation process:

- Helpful: 83.9%
- Neutral: 13.7%
- Unhelpful: 2.3%

*More than 97% of clients found this practice helpful!
Concurrent Documentation Setup

- **Scripts** – know how you are going to introduce to patients before the session
- **Technology** – what is needed/available?
- **Office Setup** – do computers or furniture need to be re-arranged?
- **Time/Flow** – real time for assessments/tx plans, beginning and end for progress notes
- **HIPAA** – be careful other information on the computer is not seen by the client
- **Clinical judgment** – will not work in every situation
“We are going to utilize a new note taking strategy during our session today. Instead of taking notes after the session, we will take notes during the session which will allow us to better focus on and help us to be in agreement on what is being expressed. In doing so, I will allow you to read the notes I take to actively participate in the reflection process. Do you have any questions?”
“Today we will be doing something that might be new to you. I am going to take notes during the session, and then during the last five to ten minutes we will review those notes. Do you have any questions?”
Technology

- Is your internet connection and computer reliable?
- Are laptops needed for off-site services (groups, services taking place in schools, etc.)?
Office Setup

- Monitor should be between client and the clinician so it can be viewed by both, and should be easily rotated
- Always keep safety in mind
Why documentation matters!

We need to value documentation as a representation of the clinical processes it represents:

- Assessment
- Treatment Planning
- Clinician–Client interactions
- Clinical progress
The Documentation Linkage

Psychosocial Assessment → Treatment Plan → Progress Notes
The Documentation Linkage

Psychosocial
- Diagnoses
- Strengths/Challenges
- Assessed Needs/Personal Goals

Treatment Plan
- Goals and Objectives
- Should link to assessed needs and goals from initial assessment

Progress Notes
- Interventions
- Clinical progress
Psychosocial Assessment

Goal: Establish qualification for services
• Symptoms
• Functional impairments/ consequences
• DSM–V diagnosis (supported by symptoms)
• Identify strengths, challenges
• History – has person been diagnosed previously by another qualified provider?
• Identify assessed needs to be developed further in treatment plan
The assessment is the time we get the most information from the patient and it is often our baseline for care. So much information to gather, we should ensure we are understanding it correctly from the patient. This also decreases time spent on charting after hours.
# Psychosocial Section Example

<table>
<thead>
<tr>
<th>CFI</th>
<th>Presenting Information</th>
<th>Social Information</th>
<th>Individual/Family Information</th>
<th>Social Supports</th>
<th>Medical History</th>
<th>Psychiatric Illness History</th>
<th>Trauma</th>
<th>Risk and Alerts</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Living Situation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Housing/Living Situation</strong></td>
<td>Foster Care</td>
<td>Guardian</td>
<td>Homeless Shelter</td>
<td>Rent House or Apartment</td>
<td>Nursing Home</td>
<td>Relative</td>
<td>Respite Care</td>
<td>Friend</td>
<td>Homeless</td>
</tr>
<tr>
<td>Do you live with anyone?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At risk of losing current housing?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with current living situation?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Is individual unsafe due to inadequate living conditions?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**Education**

<table>
<thead>
<tr>
<th>Education history</th>
<th>Has High School Diploma</th>
<th>Has GED</th>
<th>Other</th>
<th>College</th>
<th>Vocational training</th>
<th>Currently enrolled</th>
</tr>
</thead>
</table>

**History of learning difficulties**

- none reported
- deaf-blindness
- visual impairment
- orthopedic impairment
- cognitive impairment
- preschoolers with a disability
- traumatic brain injury
- special school placement
- multiple disabilities (not deaf-blind)
- deafness (hearing impairment)
- speech or language impairment
- emotional impairment
- specific learning disability
- autism
- other

**Current barriers to education**

- None
- Inability to read or write
- Other
**History of Developmental Disabilities**

Developmental history (include motor development and functioning, sensory, speech problems, hearing and language problems)

**Financial Information**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>How is individual supporting himself/herself right now?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>child support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>employment</td>
<td></td>
<td></td>
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<tr>
<td>HMAIDS service administration</td>
<td></td>
<td></td>
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<tr>
<td>public assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>rental income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>social security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>social security disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>supplemental security income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>unemployment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>worker’s compensation/disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>food stamps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have there been times when the individual cannot afford the things he/she or his/her family needs?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Is individual going without necessary medication due to financial hardship?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does the patient have Advanced</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
### Financial Information

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>child support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS service administration</td>
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<td>public assistance</td>
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<tr>
<td>food stamps</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Have there been times when the individual cannot afford the things he/she or his/her family needs? [Yes/No]
- Is individual going without necessary medication due to financial hardship? [Yes/No]
- Does the patient have Advanced Directives in place? [Yes/No]

**Comments:**

### Legal Information

<table>
<thead>
<tr>
<th>Involvement with the legal system</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

- Does individual currently have health insurance? [Yes/No]
Example summary:

“Patient is a 42 year old male presenting today with symptoms consistent with Generalized Anxiety Disorder, including: excessive worry about work performance, fatigue, irritability, and difficulty sleeping for the last 12 months. This is the first time he is seeking counseling services for these symptoms. He states decision to seek services today is based on the fact that his marriage has been suffering as a result of his symptoms, including frequent arguments, at least three times a week, with his wife. He identifies his family as a source of support but is having difficulty accessing this support due to these frequent arguments.”
Why use collaborative documentation in treatment planning

- Our job is to assist the patient in reaching their goals and objectives for care
- Treatment plans must be done collaboratively, or they may be incorrect or inaccurate
Treatment Plan

Goal: Establish a plan for how assessed needs will be met in course of treatment and how this will be measured

Example Treatment Plan Goal:
“Goal 1: Decrease frequency of arguments with wife from three times a week to no more than once a week after 6 sessions”
<table>
<thead>
<tr>
<th><strong>Treatment Plan Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment Plan Type:</strong></td>
</tr>
<tr>
<td><strong>Treatment Plan Completed/Reviewed Date:</strong></td>
</tr>
</tbody>
</table>

**Patient strengths, including cultural, linguistic and spiritual strengths, that will be utilized in treatment:**

- Patient is self aware
- Patient reports high level of motivation to decrease symptoms and increase mood
- Patient has been consistent with all appointments scheduled thus far in treatment
- Patient stated: “I have a real faith that I can improve and that helps me come in every week”

**Current social supports that will be utilized to meet short term goals:**

- Patient has a strong support in his wife of 40 years
- Patient has children and grandchildren he feels that he can be open with them regarding some of his concerns

**Potential barriers to meeting short term goals:**

- Patient does not report any concerns regarding meeting his short term goals at this time
## Treatment Plan

<table>
<thead>
<tr>
<th>Patient reported physical symptoms or medical diagnoses effect on behavioral health:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient reports that some of his medical concerns, including “growing pains” add to his stressors. This will be explored continuously in treatment collaboratively with patients doctor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History of medical hospitalizations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>None reported</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How will provider/individual/guardian know that level of care change is warranted (include cultural linguistic and spiritual indicators)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>“When I feel like I can manage this on my own, that is when I know it is time to leave therapy. I guess I also just do not want to be as anxious on a regular basis”</td>
</tr>
</tbody>
</table>

Discharge plan (Indicate the anticipated plan for discharge, including treatment, support services and community resources):
Why use collaborative documentation in the progress note

- It can help us focus ourselves and the patient during session
- It includes our goals and objectives, which we can use throughout the session to track our interventions and progress
What is an “effective” progress note?

- Readable – not too “clinical”
- Useful to:
  - Patient
  - Clinician
  - Others involved in patient’s care – docs, nurses, collaterals, others?
Goal: Continue to show clinical necessity by documenting current symptoms and impairments as well as clinical interventions

Should include:
• Current symptoms
• Goal(s) from treatment plan addressed in session
• Interventions used in session (don’t just name the modality—show HOW its used)
Example:
“Today patient reports continued generalized worry, fatigue, and irritability; sleep is slightly improved from baseline with patient reporting he was able to sleep at least 6 hours five out of seven nights this past week. Today’s session focused on patient’s progress towards Goal #1. He reports two arguments with his wife in the past week; states he was able to avoid an argument in a third instance through use of de-escalation techniques explored in last session. In today’s session clinician assisted patient with identifying more de-escalation techniques to use in the coming week to avoid arguments with his wife. Patient agrees he will try counting backwards from ten the next time he feels irritable or provoked.”
I have identified this individual to be Fred Acanthite, 5/20/1950

Individual is here to address symptoms of the following: Generalized Anxiety Disorder

- Individual reports taking medication. Individual and worker discussed medication regimen. Individual reports 100% compliance for the past 7 days. Individual reports the following barriers to adherence: none. Individual reports side effects: (nervous/irritable frequency or severity: moderate. Loss of energy frequency or severity: moderate. Social withdrawal frequency or severity: moderate.

- Individual is oriented to: time, place and person. Individual appears within normal limits. Individual's mood is unremarkable and anxious. Individual's affect is appropriate to content. Hallucinations: not present. Individual's thought content: Suicidal ideation: none. Homicidal ideation: none.

Intervention(s) provided: Worker assessed patient's current symptoms and stressors. Worker used active listening in regards to patient's continued difficulties managing his stressors with his anxiety. Worker initiated dialogue surrounding patient's concerns with his new medication regimen and the side effects it causes. Worker used positive reinforcement in regards to patient going for bike rides as this has assisted him in the past. Worker conducted the GAD-7 with the patient to assess for anxiety related symptoms.

Despite the intervention, the patient continues to have anxiety symptoms affecting daily functioning.

Individual's response to intervention: Patient was engaged and open to interventions. Patient reports that his medication is helpful, however causing him increased fatigue. "I feel less anxious I guess but do fear that his bike rides continue to be a positive outlet for him. Patient reports that he will speak to his psychiatric provider regarding his concerns with side effects of the medication.

Plan (indicate action plan between sessions): Patient will go on one to two bike rides between now and next session. Patient is scheduled to meet with psychiatric provider to review medication management.

Progress on goals addressed during the session:

<table>
<thead>
<tr>
<th>Goals</th>
<th>Today</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Goal: GAD-7 Total &lt; 7</td>
<td>8</td>
</tr>
<tr>
<td>I will take all my medication as prescribed by my psychiatric provider in order to assist in decreasing anxiety</td>
<td>On track</td>
</tr>
<tr>
<td>Behavioral Health Objective:</td>
<td></td>
</tr>
<tr>
<td>to make sure I am taking my medication I will report any side effects to my doctor</td>
<td>On track</td>
</tr>
<tr>
<td>General</td>
<td></td>
</tr>
<tr>
<td>I want to not feel as anxious I used to (pt-stated)</td>
<td>Not on track</td>
</tr>
<tr>
<td>I will ride my bike because it makes me feel better (pt-stated)</td>
<td>On track</td>
</tr>
</tbody>
</table>

Emory-Swi Aegea
Date: 3/29/2017
Some More Tips

- Make it readable. Avoid too much clinical jargon.
  - Would the patient agree/understand?
- Use the progress note as a way to structure your work. It fits nicely with evidence-based models!
Engagement

- Documentation is historically a private exercise
- Push for proactive, patient-centered care
- Are the goals and objectives for treatment truly being addressed? Does the client agree?
The “Holy Grail” of Documentation?

- Fast and easy to perform
- Completed in a timely manner
- Preferred by clinicians and clients
- Guides clinical activity and episodes of care in a rational direction
- Improvement in note quality and patient engagement in care
Doing this in the room

- For many, this is a large shift.
- Let’s take some time now to talk about why that is and the ways we can work within this model.
- What are some of the barriers that you think would arise using this model?
Thank you, questions or concerns?

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