



SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Collaborative Documentation: A Clinical Tool

Presented by:

Katherine Hirsch, LCSW, M.T.M Clinical Consultant

M.T.M. Services, LLC

630-301-0554

katherine.hirsch@mtmservices.org

mtmservices.org

What is Collaborative Documentation?

- Collaborative Documentation (CD) is a process in which clinicians and clients collaborate in the documentation of new and updated assessments, new service plans and reviews, and progress notes- office based or in community with individuals, families & groups.
- 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 providers the opportunity to clarify their understanding of important issues and focus on outcomes.
- The client must be present and engaged in the process of documentation development.

Re-Integrating Clinical Practice and Clinical Documentation

- Documentation has become “The ENEMY”
- Clinicians count on “no-shows” to complete paperwork and catch up
- Clinicians report that documentation competes with time spent with clients and is divorced from the clinical work
- Goal is to integrate documentation and the clinical process
- We need to stop thinking of clinical documentation as paperwork!

Resistance

People believe that:

- CD will harm the therapeutic relationship
- CD will decrease engagement with the clients
- Staff will pay too much attention to the computer rather than the client
- Time with client will be cut
- Writing with the client is not billable
- Documentation is our communication to treatment teams, potentially legal system but not the client
- **We must remember that with HIPAA this is the client's chart and this is communication with/for them too!**

Collaborative Documentation Can:

- Improve client engagement and involvement
- Help focus clinical work on change and positive outcomes
- Improve compliance
- Save you time and create capacity
- **Improve quality of life of clinicians**

Collaborative Documentation Requires a Shift in Thinking

- We need to **stop** thinking of clinical documentation as paperwork and start thinking about it as the **clinical work**.
- Be prepared to be more **transparent** as a provider.
- Be prepared to **decrease** how much you are writing. A great note does not mean a long note.
- Remember that it is OK to **agree to disagree**.
- Be prepared to **shift your language** to client friendly language that will still maintain medical necessity. Use clients' language and terms that client can understand and/or relate to because using technical terminology can negatively impact treatment.

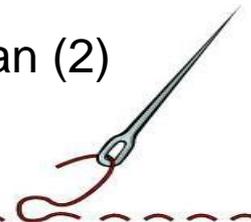
Documentation Strategies That Support Collaboration

Key is to develop a **meaningful** “clinical narrative” that follows the Golden Thread so that Collaborative Documentation can support:

- A natural, meaningful conversation
- Efficiency
- Medical necessity and compliance

Medical Necessity implies focus on functioning in three key documents

- Pulling the “Golden Thread” from the diagnostic assessment (1) through to the individualized treatment plan (2) and finally to the progress notes (3)



Diagnostic Assessment	Treatment Plan	Progress Notes
Describing signs and symptoms associated with diagnosis is not sufficient; <u>must describe specific functional impairments</u>	Symptom-based plans are not enough; <u>must include functionality-based treatment goals</u>	Progress reviews cannot be purely subjective; <u>must document specific and measurable improvements in functioning</u>

Collaborative Documentation: Intake/ Assessment

Introduce the plan for meeting including how you will work collaboratively to accurately represent the information they are telling you today.

Take one content section at a time

- Presenting problem
- Psychiatric and substance use disorder treatment history
- Family Hx, etc....

Discuss the section with the client/ family

Enter into system allowing client to see and comment/clarify

2 Ways

- **The great typist** can type while he/she talks and review before moving on to next section.
- **The limited typist** can talk and then review and type before moving to the next session.

Collaborative Documentation: Intake/Assessment

Diagnoses

Talk with client about what diagnoses really are and then share your current conclusions and document with client. Use the symptoms they describe and how they are impacting functioning.

Interpretative/Clinical Summary

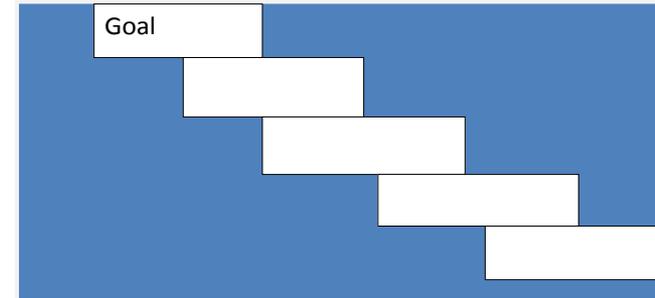
Say, “OK, let sum up what we’ve discussed today.” Document with the client.

Identified Needs/ Problems

- Develop clearly identified and prioritized Behavioral Health Needs (Problem Areas) that can be used to establish goals.
- Utilize the current symptoms and functional needs to identify the clients assessed need. This will be the link from the assessment to the goal.
- 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.



Collaborative Documentation: Treatment (Service) Plan Goals



Definition:

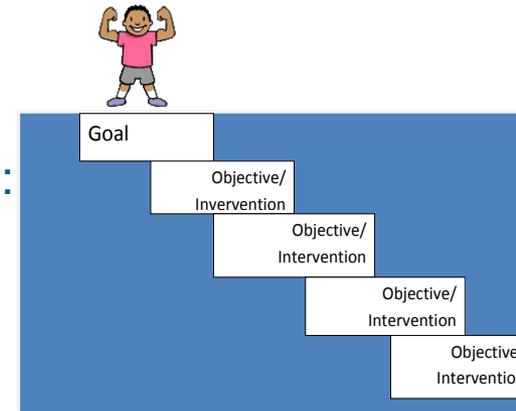
- A goal is a general statement of outcome related to an identified need in the clinical assessment.
- A goal statement takes a particular identified need and answers the question, “**What do we want the outcome of our work together to be, as we address this identified need?**”
- Discuss and enter a collaborative statement that makes sense to the client.

Collaboratively Documenting Treatment Plan

Objectives

Attempt to develop a measurable and observable outcome 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



Remember: Objectives are important to allow you and the client to tell if the work you are doing together is working.

Interventions

- Discuss the Intervention(s)/Strategy(s) that will be used to help achieve the objective.
- Document with the client. Help them understand that this is what you will do to help them achieve their objectives (Walk up the staircase).

Services

- Discuss the modality/service for the intervention(s) and the frequency and duration.
- Review recommended frequency and confirm the commitment.

Treatment Plans Set the Stage for Collaborative Documentation of Progress Notes

- Having useful treatment plan goals and objectives makes collaborative documentation of progress notes easier in terms of:
 - Compliance – Need to relate sessions to treatment plan
 - Engagement – Assessing progress helps engage and encourage clients
 - Utilization of the plan as the map to treatment: If treatment plan becomes irrelevant – update it!
 - If objectives aren't being met – what do we need to change?

Keys to Completing Progress Note

- Be aware of the treatment goals and objectives
- Start every session by reviewing the previous weeks note (plan section)
- Break up the note (May complete mental status at beginning of the session)
- Interact normally with the client during session
- Wrap-up the session and complete note collaboratively

Collaborative Documentation as a Clinical Tool

- **The plan was a much more powerful section when completed with the client**
 - Tasks or skills that the client had agreed to try were noted and reviewed at the beginning of the next session. **(What is the client going to do)**
 - Tasks that I agreed to complete were noted and reviewed at next session as well. **(What is the staff going to do)**
 - Topics that we did not have time to address. **(What are we going to do together at the beginning of the next session)**

How do I do a CD progress Note?

At end of session (time usually used for “Wrap Up”) say, “Lets review, SUMMARIZE and write down the important parts of our session today.”

1. New, salient information provided by client
2. Changes in mental status
3. Goal(s) and objective(s) that were focused on
4. Interventions provided
5. Client’s response to intervention (today) “What did we do today that was helpful?”
6. Client’s progress re: the goal/objective being addressed
7. Plan for continuing work

Transition from Post Documentation to Collaborative Documentation

“Do as Much as You Can” approach
(and/or “Do as Much as Your Client Can”)

- a. Set your goal of completing CD at least 93% of the time
- b. Set objectives to meet this goal
- c. Make the objectives for yourself measureable and obtainable
- d. Determine what you need to support you in achieving your objectives
- e. Remember not to let the exception become the rule

How to Introduce Collaborative Documentation to Clients

If you develop a script for how you will introduce this process to a new client or review and implement with an existing client, it can help with your success.

How to Introduce Collaborative Documentation to Clients

The key is to know what you want to say:

Script Elements –

- This is your note/chart
- This is your care
- I want to accurately state what you are saying
- I want to indicate what you are getting from our time together versus what I think or hope you are getting
- 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

Collaborative Documentation Strategies

General Tips:

- Assume that your clients will read their documentation.
- Let clients see the computer/documentation as it is being developed.
- Agree to disagree!
- Do as much as you can.
- Identify the aspects of documentation that are most important to do collaboratively.
- 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.

Questions and Discussion

Please ask Questions! Here are some common ones...

What if a client says “I don’t want to document during the session”?

What if there is something the client says they do not want documented?

How do I use CD with parents/families?

How do I use CD in Collateral Meetings?

How do I do CD in groups?

How do I do CD in the community, schools or in people’s homes?

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 CD during a telephone call?

