Collaborative Documentation: There's Nothing Basic About It

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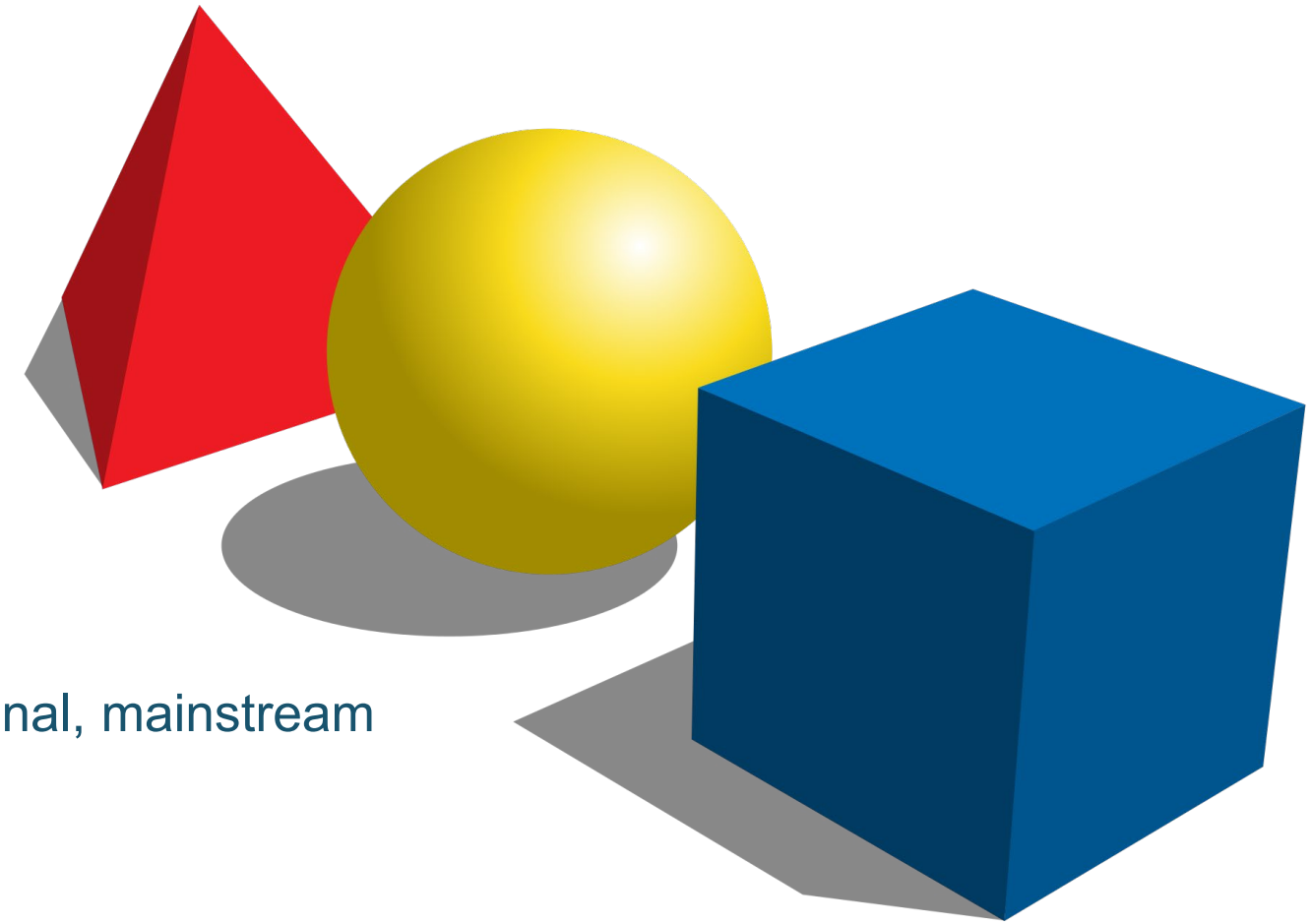

ba·sic /ˈbāsik/

adjective

1) Boring, unexceptional, unoriginal, mainstream

Things that are basic:

Photo credit: gstockstudio

NOT basic:

Photo: thenextweb.com

Why Struggle,

when you can *slay*?

The Transition to Collaborative Documentation
Why we are committed to CD

- Stop needing to work nights and weekends
- Documentation improves as it becomes a true reflection of the treatment session
- The documentation becomes more *valuable*
- Clients engagement in treatment improves
- **QUALITY OF LIFE IMPROVES**

Objectives for today….

- Demonstrate the benefits of a collaborative documentation style – to the consumer and the provider.
- Discuss strategies for using collaborative documentation in challenging situations.
- Illustrate how collaborative documentation supports better performance in the VBP, outcome-focused environment.
- See how Collaborative documentation improved client engagement, improved treatment outcomes and improves both client and staff satisfaction.
- Collaborative Documentation IRL

What is Collaborative Documentation?

CD allows the service provider to confirm with the consumer/family in a proactive manner:

- The goals and objectives addressed during the session
- The therapeutic interventions provided by the direct care staff
- Their feedback regarding progress made and an indication of their perceived benefit of the service.

- In addition, this practice is an appropriate extension of the therapeutic interaction that could serve to focus the client/family on what just occurred in the session as well as their next steps in the process of recovery/resiliency.

Think about it….

- How much time do you spend in documenting clinical services after the consumer has left your office?
- How many times are you logging in after hours to complete needed documentation?

On average

Staff are spending 10 plus hours a week in post session documentation.

FTEs	Hours/week	Total hours per week	Number of Billable Weeks	Total hours per year	Average Rate of Reimbursement	Cost of Post Session Documentation
1	10	10.00	48	480.00	$ 85.00	$ 40,800.00

FTEs	Hours/week	Total hours per week	Number of Billable Weeks	Total hours per year	Average Rate of Reimbursement	Cost of Post Session Documentation
100	10	1,000.00	48	48,000.00	$ 85.00	$ 4,080,000.00

National Trends

- Minimally: Documentation completed and turned in with in 24 hours
- Most providers are moving to Same Day documentation
- 100% accuracy on all clinical documentation (quantitative and qualitative compliance)
- Direct Service standards: 65% of Paid time
  - 113 direct client hours per month
  - 1352 direct client hours per year

Why Collaborative Documentation?

- For Clients, it improves engagement.
- For Clinicians, it saves valuable time.
- For the Organization, it improves documentation accuracy and compliance.

Client Benefits with CD

- Increased engagement
- Clients participate in their treatment goals and discussion of progress = Client-Centered Treatment.
- Opportunity to provide valuable feedback to the clinician– what is working, what is not working.

Increased Engagement

Teams who implement CD see about a 10% increase in client show rates immediately after implementation.

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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	1195	4%
2 Not helpful	352	1%
3 Neither helpful nor not helpful	2564	9%
4 Helpful	8888	31%
5 Very Helpful	14988	52%
NA No Answer/No Opinion	756	3%
Total/Approval %:	**28,743**	**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	625	2%
2 Not involved	255	1%
3 About the same	3722	13%
4 Involved	7714	28%
5 Very Involved	14672	53%
NA No Answer/No Opinion	817	3%
Total/Approval %:	**27,805**	**97%**

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	113	0%
2 Poorly	62	0%
3 Average	1136	4%
4 Good	6561	24%
5 Very Good	19331	70%
NA No Answer/No Opinion	531	2%
Total/Approval %:	**27,734**	**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	1440	5%
2 Unsure	3276	12%
3 Yes	20687	77%
NA No Answer/No Opinion	1527	6%
	0	0%
	0	0%
Total/Approval %:	**26,929**	**94%**

Clinician Benefits with CD

Better client engagement. If our mission is to help people recover, then the first step is getting them to show up!

Clinician Benefits with CD

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- Saves time -- helps to achieve a better work-life balance.

CD vs. Post-Session Documentation

Time Savings

- Transitioning from Post-Session Documentation Model to Collaborative Documentation Model gives you back valuable time to do what you were trained to do.

- Example: Staff that are taking 10 minutes to write a progress note are using approximately 200 hours over the course of a year just to write those progress notes.

Creating Capacity and Improving Quality of Work life

Progress Notes

Billable Hours Per Year	1,200
Operational Weeks Per Year	46
Average Session Length	60

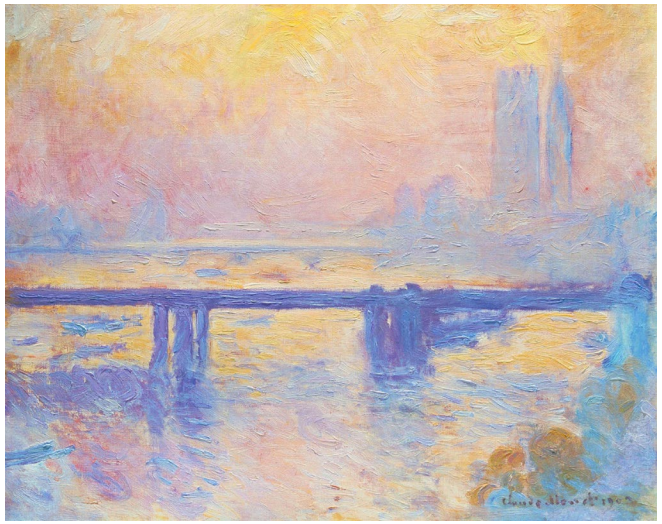
PN Time Per Session (min.)	Total:			
	Mins	Hours PD	Hours PW	Hours PY
5	6,000	0.43	2	100
7.5	9,000	0.65	3	150
10	12,000	0.87	4	200
12.5	15,000	1.09	5	250
15	18,000	1.30	7	300

Clinician Benefits with CD

- Better client engagement. If our mission is to help people recover, then the first step is getting them to show up!
- Saves time -- helps to achieve a better work-life balance.
- Improves documentation accuracy and compliance.

Documentation Accuracy

- By documenting collaboratively, we have an accurate representation of what occurred during client sessions.
- The more time that passes between the session and when it is documented, our memories begin to fail and documentation gets more vague, homogenous, and less helpful.
- Having to stop, think, recall and then write will take more time and we end up documenting what we ***hope*** the client took from session, not what we can confirm that they understood.



Benefits to the Organization

- Improves documentation accuracy and compliance.
- Improves documentation timeliness – this benefits **everyone** on the treatment team.
  - What you do is important!
  - Other providers within your organization and increasingly outside your organization (e.g. physical healthcare partners) should have the benefit of your documentation when they need it.
  - CD protects from care coordination and risk management issues.
  - We need to move to “real time” documentation availability (or as close as possible.)

Demonstrating Value

Collaborative Documentation in the era of Value-based Payment

Value of Care Equation

1. Customer Service: The ability of all team members to be engaged to meet and exceed internal and external customer service expectations and improving the Customer Service Experience to Achieve Better Outcomes at a Lower Cost.
2. Services provided – Timely access to clinical and medical services, service array, duration and density of services through Level of Care/Benefit Design Criteria and/or EBPs that focuses on population based service needs.
3. Cost of services- provided based on current service delivery processes by CPT/HCPCS code and staff type.
4. Outcomes achieved- (i.e., how do we demonstrate that people are getting "better" such as with the DLA-20 Activities of Daily Living).
5. Quality -Value is determined based on can you achieve the same or better outcomes with a change of services delivered or change in service process costs which makes the outcomes under the new clinical model a better value for the payer.

Collaborative Documentation in Real Life

Collaborative Documentation Often Requires a Shift in Thinking

General Tips:

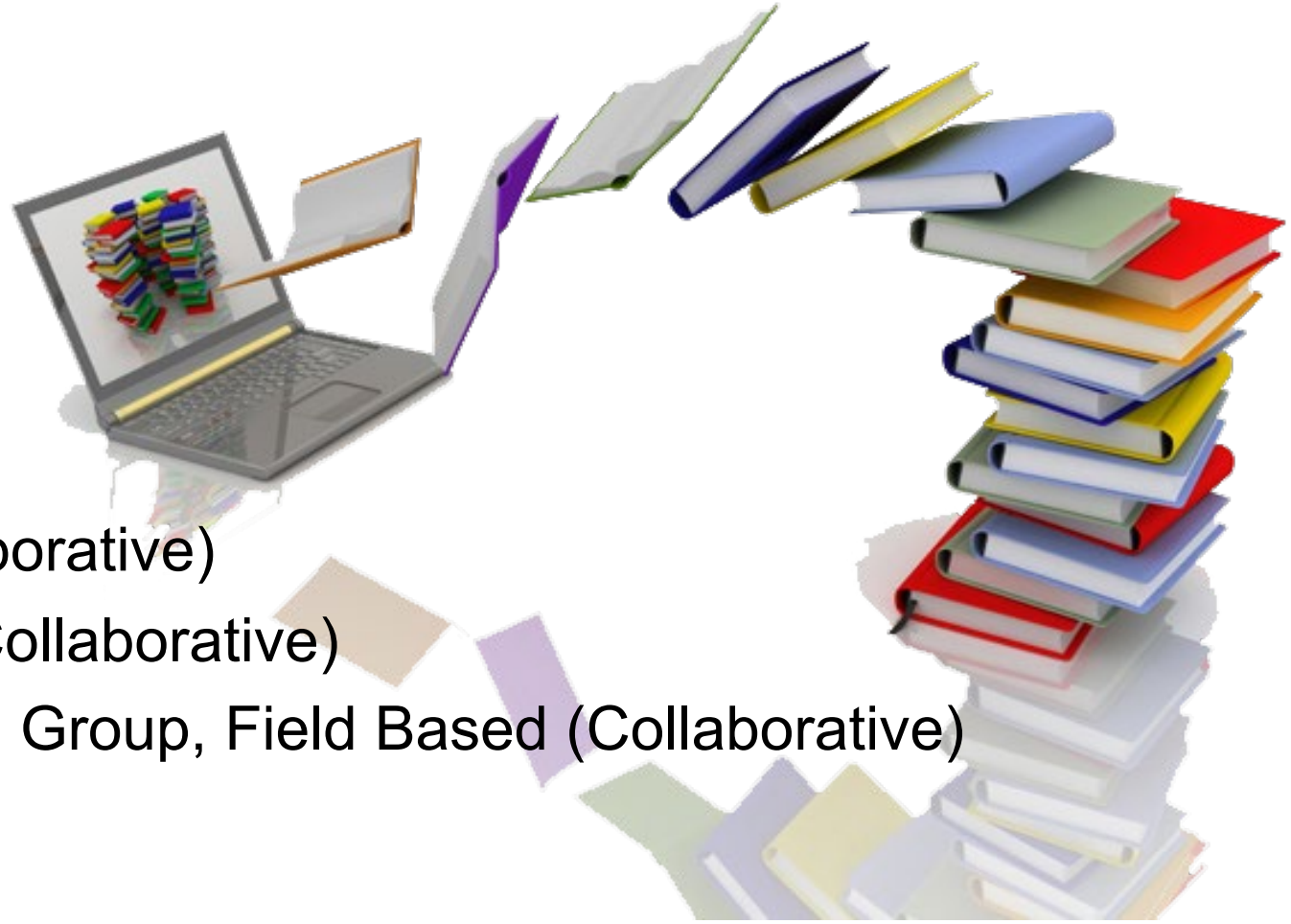
- We need to stop thinking of clinical documentation as paperwork and start thinking about it as the clinical work.
  - Remember your attitude about Collaborative Documentation will impact your success
- Be prepared to be more **transparent** as a provider!
- Be prepared to **decrease** how much you are writing. A great note does not mean a long note!
- Do as much as you can and use your clinical judgment.
- Allow clients to surprise you.

Collaborative Documentation Often Requires a Shift in Thinking

Specific Tips:

- Don't abandon your clinical style, just incorporate more collaboration with your clients.
- Avoid certain language whenever possible: technical jargon, labeling, judgmental language.
- Remember that it is OK to **Agree to Disagree**!
  - One common fear among service providers is that clients will resent or disagree with what is being documented.
  - Experience demonstrates that clients accept that providers need to document their observations and perspectives as long as the clients' and/or parents' perspectives are documented as well.

Collaborative Documentation



Appropriate for use:

- Assessment (Concurrent and Collaborative)
- Service Planning (Concurrent and Collaborative)
- Progress Notes - Individual , Family, Group, Field Based (Collaborative)

Sample "Office" Setup

Can your client see your screen?

Collaborative Documentation

- Collaborative Documentation is not negotiating what is documented in the record.
- The clinician must document objectively.
- To be considered Collaborative the client should:
  - Know what is being documented (ideally via visual access)
  - Have the opportunity to ask questions
  - Have the opportunity to have disagreements and to have their perspective documented
  - Have the ability to correct objective (factual) errors.

CD as a Clinical Tool with Progress Notes

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

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

Intervention(s) / Method(s) provided: (What is the clinical provider's impression of the session/What makes the note billable.)

Response to Intervention/Progress toward goals and objectives: (What is the client/s impression of the session/ Positive or Negative)

Plan/Additional information (Indicate action plan between sessions/meetings): (Based upon feedback from the client, what will be our next steps/homework between now and next session.)

Print Staff Name/Credentials/Title:	**Staff Signature:**	Date:
Print Supervisor Name/Credentials/Title (if applicable)**:**	**Supervisor Signature:**	Date:
Individual's Signature (Optional)**:**		Date:

Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes

SOURCE: NYSCRI

What's wrong with this Progress Note for a 50 Min Individual Therapy Session?

Client Goal: "I want to be able to control my anger and get along with people"
Objective: Reduce serious arguments with family to fewer than one per week

- "Client came to session on time and was dressed appropriately. He was pleasant and cooperative but reports feeling more depressed this past week. Client reported that problems with his parents have not gotten better. They continue to make demands and treat him like a child which makes him angry so then he loses his temper and argues with family. He reports that this makes him feel guilty and alone. Undersigned validated clients feelings and provided encouragement
- Client reports taking his medication as prescribed. He has appointment with Psychiatrist next week.
- Client continues to have poor insight regarding his role in family disputes which prevents him from improving his situation. He blames others for most of his problems.
- The client poses no threat of physical harm to others at present.
- Next appointment two weeks

Alternative – Formatted CD Note

Client Goal: "I want to be able to control my anger and get along with people"
Objective: Reduce serious arguments with family to fewer than one per week

New Information/ Interim Update:

- "John reported that he has been feeling more depressed this past week and that he is continuing to have problems with his family. He reports that he's been taking his medication.

Intervention:

- Therapist used examples provided by John of recent family confrontations to review strategies for avoiding angry outbursts. We role played some examples so John could practice. We also worked to identify whether there are some things he can do, like doing chores before being told, that might make things easier for him at home.

Client Response:

- John worked well in session and agreed that techniques made sense but he has problems thinking of doing them when at home. Indicated he would try.

Progress:

- John is learning techniques but still needs to use them more in order to achieve his Objective related to reducing family arguments. He reports at least 3 arguments this week.

Plan:

- John will use at least one techniques practiced today and work on doing chores before being asked. John has appointment with his psychiatrist this Week.

CD As A Clinical Tool during Progress Noting

The "Plan" section of the progress note is much more powerful when completed with the client.

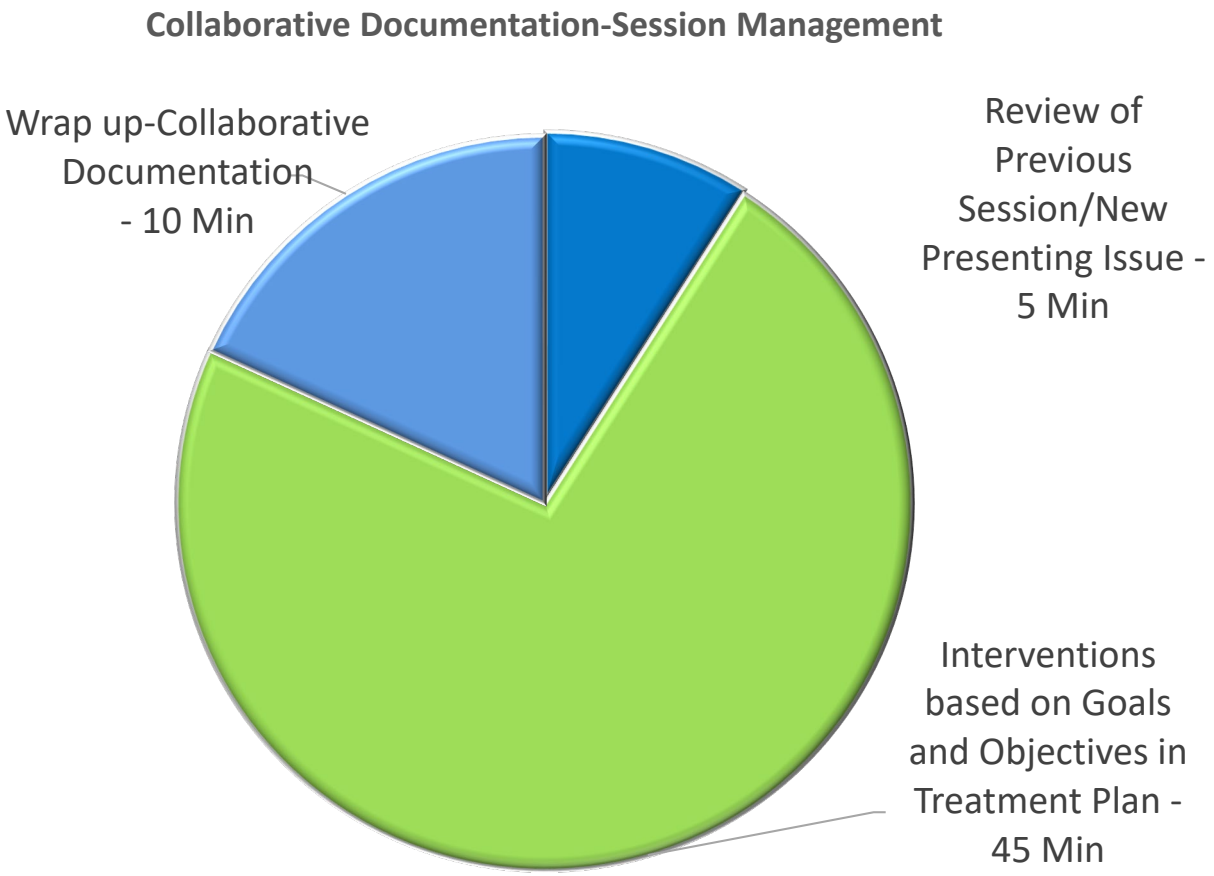
- Tasks or skills that the client agrees to try are noted and reviewed at the beginning of the next session. **(What is the client going to do between now and next time?)**
- Tasks that the clinician agrees to complete are noted and reviewed at next session as well. **(What is the staff going to do?)**
- Topics are noted here that were not addressed, due to time. **(What are we going to do together at the beginning of the next session)**

Running the Session

Basic Approach (may vary by service type):

- Be aware of the treatment goals and objectives.
- Start with the “Plan” from the last interaction (i.e. what will the client and possibly the provider do between sessions or what will be the focus of the next session).
- Interact normally with the client during session/interaction possibly taking notes on pad saying “I’m going to jot down a few words so we’ll remember when we write our note at the end of the session”.
- At end of session (time usually used for “Wrap Up”) say “Let’s review and write down the important parts of our session today.”

Example of Session Management



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

CD Tips for Resistant Clients

- Plan for area(s) of the note you will document together.
- Develop and practice your script.
- Identify the areas of resistance and root cause
- Pull the note up so the client can see as you document
- Assure the client that what is written is their response to services
- Use the documentation to empower the client interaction

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.

CD with Children: Brief Overview

- Encourage them to tell the story about today's session.
  - If adult is available, ask them to join the meeting. "Can you tell your mom what we did today?"
  - If no adult is available, "when you see ____, what will you tell her about our time today?
- Use simple rewards.
- CD Activity Bag: Identify activities a client can do while completing the note- Squiggle game, jumping jacks, coloring, stress ball. Reserve these activities for only during the wrap-up.
- Explain the need for their help with your "homework." Help client understand what you need from them and how their input will help you.

CD with Groups- Brief Overview

Works for:

60 minute groups with max of 8 clients
90+ minute groups with max of 12 clients

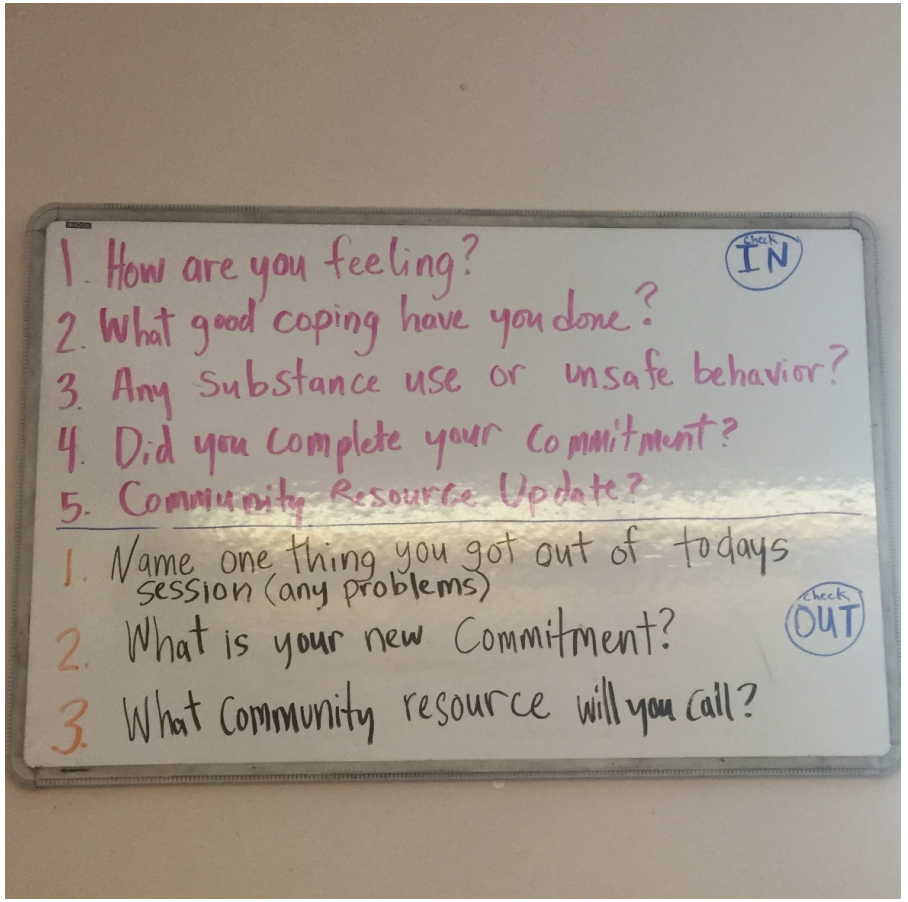
- Tell clients prior to session that they will be asked to report on what was most helpful/not helpful in group and other questions as appropriate. (e.g. "How did group help you toward meeting your treatment goals?")

- Leave 2 minutes per client at the end of the session (e.g. 7x2 = 14 minutes).

- Group facilitator brings up the first client note and summarizes overview of group session verbally and documents.

- Facilitator conducts "check-out" allowing clients to each spend 1 or 2 minutes reporting as facilitator documents.

Alternative is to document all responses on E-Form (Word) and then copy/paste into each chart later.



CD in the Field- Brief Overview

- Always assessing your environment
- Technology / Connectivity – always have a back-up plan
  - Ideal: Have connectivity to EMR or system that allows syncing later
  - Next Best Option: No Connectivity – Use word doc then copy/paste when you are back on-line.
  - Still Works: Use paper forms then type later.

- Try to form habits and do as much as you can

Photo source: macleans.ca

Collaborative Documentation Setup

How to Make it Happen:

- **Scripts –** Know how you are going to explain the process to your clients before your session.
- **Office Setup –** Do you need to move computers, screens, office furniture?
- **Technology –** Technology is great when it works but you must always have a back-up plan.
- **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.

- Questions?
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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 you do CD during a telephone call?
- What if I have a different perspective than the client?
- How do I use CD in Collateral Meetings?
- 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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