

Patient-Centered Documentation: Collaborative Documentation



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Today's Presenter

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Objectives for Today

- Establish a common language around what effective and strong progress notes looks like.
- Demonstrate how collaborative documentation is a patient-centered approach that results in better care, treatment, and notes.
- Explore the collaborative documentation model and discuss best practices for process and environment.



Why Documentation Matters!

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

- Assessment and Treatment Planning
- Clinician-Client interactions
- Clinical progress

Why documentation matters!

Document with the understanding that...

- Your client can request to read your progress notes at anytime
- Your notes can be subpoenaed
- Need to justify activities to a payor source

An Effective Progress Note

- Readable – not too “clinical” or too much jargon
- Objective neutral language
- Useful to:
 - Patient
 - Clinician
 - Others involved in patient’s care – team members, collaterals, others?
- Demonstrates **clinical necessity**

Clinical Necessity

- CMS (Centers for Medicare and Medicaid Services) definition:
 - “services or supplies that are needed for the diagnosis or treatment of a condition *and* meet acceptable standards of practice”
- Show how you are addressing the symptoms (of past 30 days) of that diagnosis in each visit.

Clinical Necessity

- Documented in two “phases”:
 1. Establish initial qualification for services
 2. Establish need for every single individual service provided



Phase 1 - Initial

- Establish that the person seeking services is qualified to receive services at the level of care you are providing:
 - ICD-10 / DSM-5 diagnosis present (must document symptoms leading to diagnosis)
 - Functional impairment that interferes significantly in the client's daily activities

Not just a “feeling” you have of what the dx is.

Phase 2 - Ongoing

- For each service, establish that the intervention you provided is necessary to:
 - Address all assessed symptoms, deficits, and functional impairments resulting from the diagnosis
 - Produce clinical improvements (or at the very least, prevent symptoms from worsening)

Language Matters!

- Remember that if clinical necessity is not documented in assessments, treatment plans, and progress notes, it *doesn't exist!*
- A good test is to read your own documentation and ask yourself:
 - 1) Would you pay out of your own pocket for that service?
 - 2) Could “anyone” provide that service?

The Documentation Linkage

Assessment

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graph TD; A[Assessment] --> B[Treatment Plan]; B --> C[Progress Notes];
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Treatment Plan

Progress Notes

The Documentation Linkage

Assessment

- 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

Assessment

Goal: Establish qualification for services

- Symptoms
- Functional impairments/ consequences
- ICD-10 / DSM-5 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

Treatment Plan

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

Progress Notes

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)

Common “Traps” to Avoid

Assessments:

- Not enough symptom information in assessment to support diagnosis
- Not capturing clinical baselines
- No documentation that clients were given the opportunity to identify their own goals for treatment

Common “Traps” to Avoid

Treatment Plans

- Not completed within required timeframes
- Goals are not clearly related to assessed needs
- Interventions not included



Common “Traps” to Avoid

Progress Notes

- Not tied to treatment plans in a meaningful way
- No documentation of skilled interventions provided
- No documentation of clinical progress (symptom resolution, etc.)



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!

Why

What's wrong with the way I am documenting now? Why should I care about collaborative documentation?



Clinician Factors



- Community Health/Behavioral Health Centers have historically high documentation-to-direct service ratio
- Reduced service capacity for the clinic, and the community
- High no show/cancellation rates
- “Overwhelmed” feeling by staff/ low staff morale

Quality Factors

Compliance Issues:

- Late documentation is poor documentation...rush to “just get it done”
- “Lost” notes
- “Boiler plate” notes
- Is the service being billed for justified by the documentation in the note? (Clinical Necessity)
 - Documentation of exact symptoms, etc.

Engagement

- Documentation is historically a private exercise excluding the client
- Push for proactive, patient-centered care
 - engages the client in the aspect of better care
- Are the goals and objectives for treatment *truly* being addressed? Does the client agree?



The “Holy Grail” of Documentation?

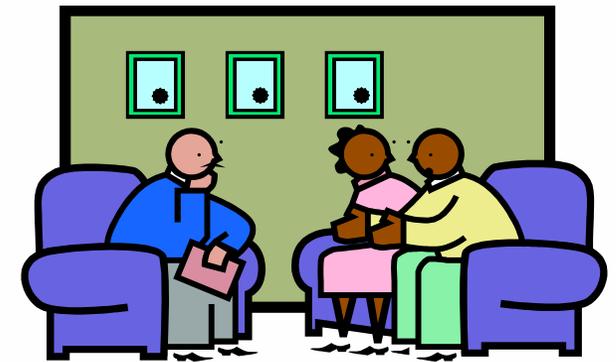
- Fast and easy to perform
- Completed in a timely manner
- Preferred by clinicians and clients
- Guides clinical activity and episodes of care in a rational direction
- Improvement in note quality and patient engagement in care



What is Collaborative Documentation?

Collaborative documentation is a practice where clinician and patient document together, during the session.

- ▶ Concurrently for assessments/treatment plans
- ▶ Beginning and end for ongoing sessions...
 - ▶ “first five and last five”
- ▶ Not Concurrent Documentation
- ▶ Integrated Care Practice



Collaborative Documentation

- ▶ A continuum of practice
- ▶ Easier over time
- ▶ Does not replace engagement skills



Collaborative Documentation

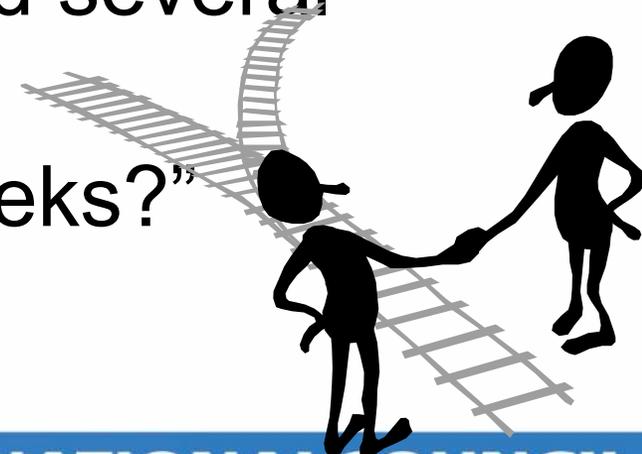
- ▶ Use patient-friendly language – or the patient’s own words whenever possible

“Patient is experiencing visual hallucinations”

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

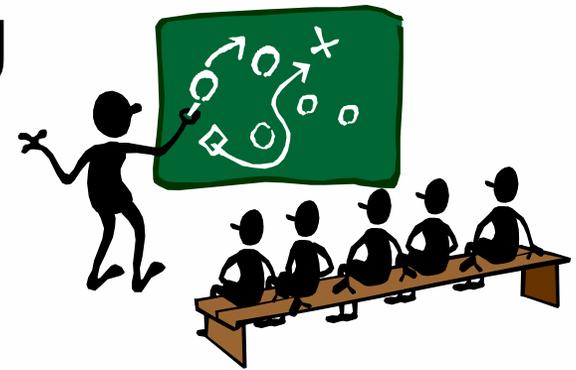
Collaborative Documentation

- ▶ Ask clarifying questions and discuss 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
 - Opportunity for shared decision making



Benefits

- 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



Benefits

- Improved clinical care/outcomes:
 - Improved engagement – patients are excited about their treatment and more “empowered”!
 - Continuity of work from session to session
 - More focus on treatment plan and goal achievement
 - Decrease length of treatment episodes
 - Complements use of solution-focused, evidence-based models
 - Patients get better!
 - Ensures immediate patient feedback

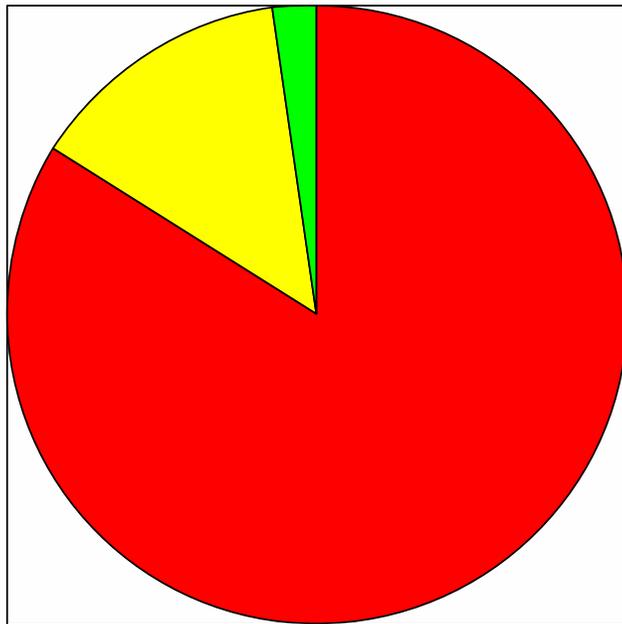


Benefits

- Supports Shared Decision-Making
- Client Satisfaction
 - Research shows that most clients (80-95 %) respond positively to the use of collaborative documentation

Case Study of Client Satisfaction

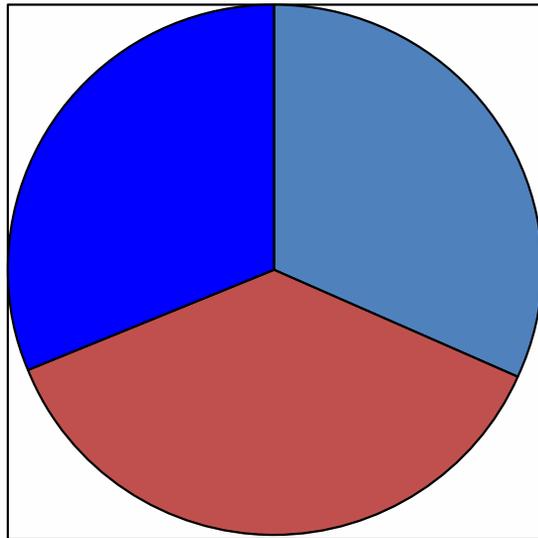
Of 927 respondents whose clinician used the collaborative documentation process:



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

Case Study of Client Satisfaction

Of 284 respondents whose clinician *did not use* the concurrent documentation process, Did they think the practice would be helpful?



■ Agree - 31.5%
■ Neutral - 36.9%
■ Disagree - 31.3%

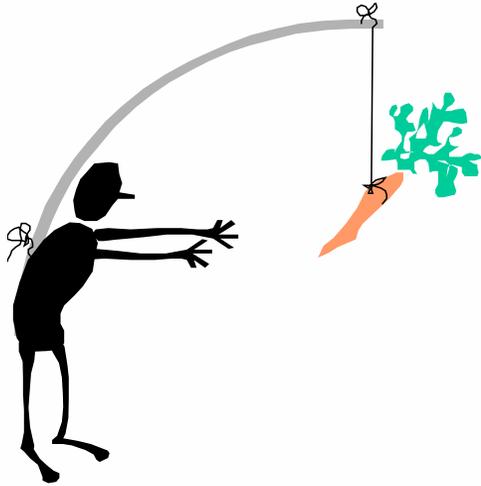
***Most patients want to try it! (68.4%)**

Benefits



- 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

Benefits



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

Collaborative 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



Sample Script #1

“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?”

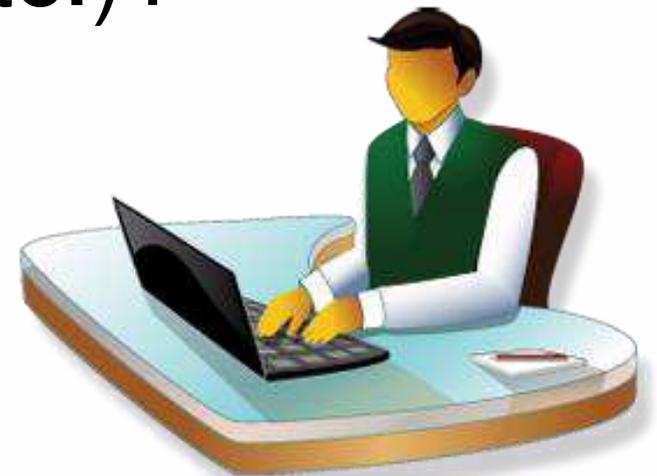
Sample Script #2

“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 progress made in the session and those notes I took. 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 viewable by both client and the clinician, and should be easily rotated
- Always keep safety in mind



Considerations for Use

- Use Clinical Judgement
- Varying Populations
- Crisis Situations
- If Client Specifically Declines It

Organizational Leadership and Support

- Technology and training support
- Acknowledge the learning curve
- Supervision

Starting the Process

- New Patients
- Try it in Sections
- Practice different ways
- Do as an opt-out model
- Be patient – this skill takes time

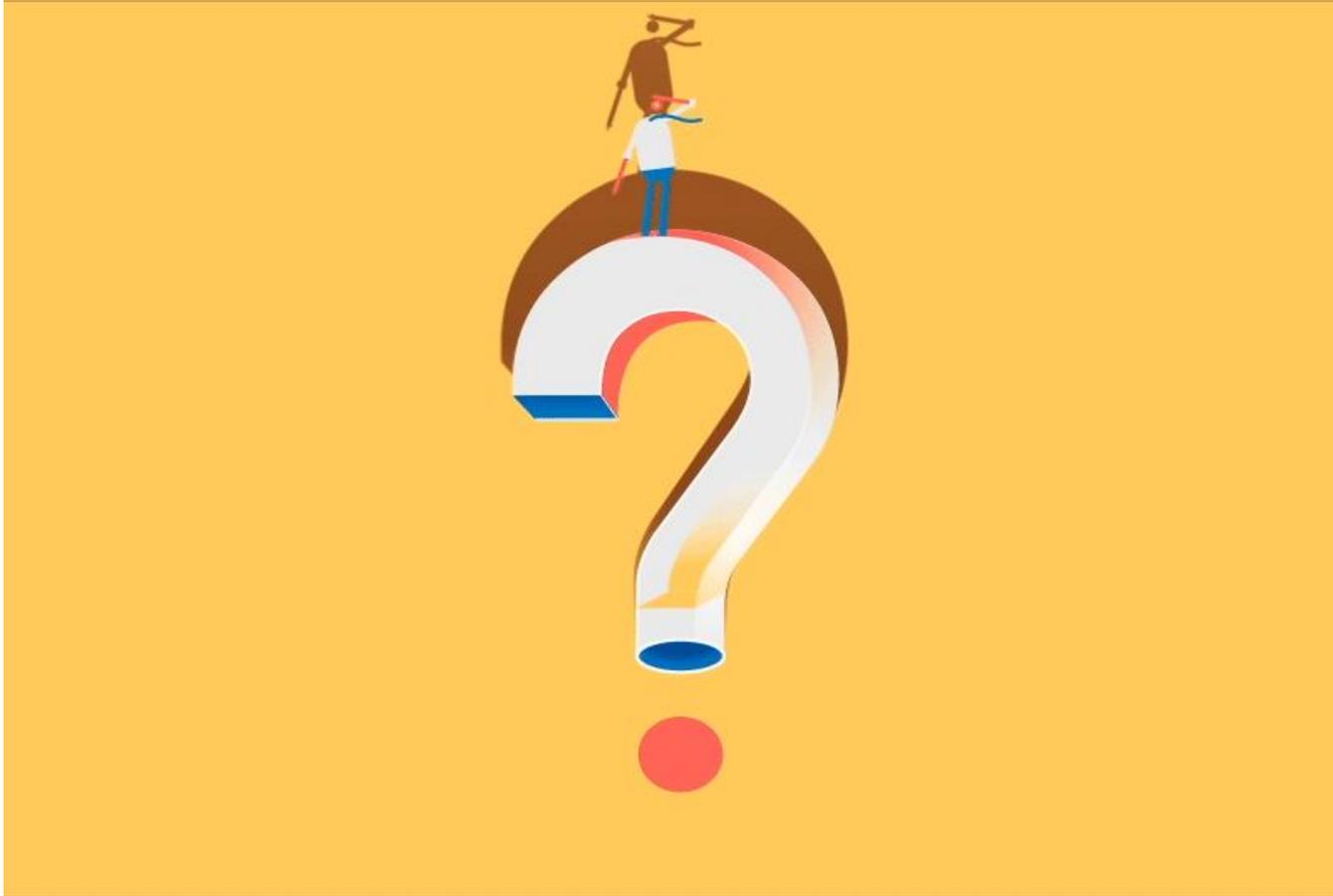
Key Points of Explanation

- Emphasize the client's importance in the process
- Explain what collaboration is and how you will work together
- Explain the parts of the note, its ok to disagree or need to clarify
- Not separate from the session but a part of the session

Remember to...

- Use patient-centered / language a client understands
- Use quotes, but sparingly
- Document differences of opinions
- Complete notes same day, but not later than within 24 hours

Discussion and Questions from the chat box?



Thank You!

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