Collaborative Documentation

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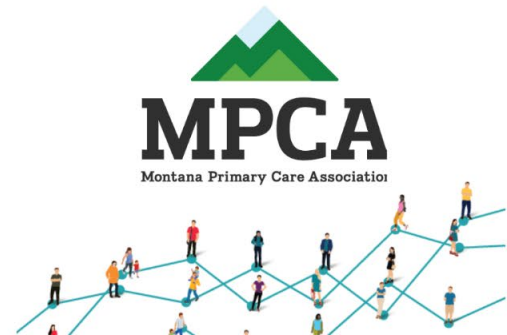
Agenda:

- Define Collaborative Documentation
- Identify Benefits of Collaborative Documentation
- Strategize Building into your Practice
- Demonstration



Cures Act

- Supports seamless and secure access, exchange, and use of electronic health information.
- Gives patients and their healthcare providers secure access to health information.
- Aims to increase innovation and competition by fostering an ecosystem of new applications to provide patients with more choices in their healthcare.

https://www.healthit.gov/topic/oncs-cures-act-final-rule

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Collaborative Documentation

- Patient is *present and engaged* during documentation.
- Notes are written in a transparent, collaborative manner with the patient during the session.
- Patients and clinicians can clarify important issues.

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Assume Your...

- Patients will read the documentation
- Notes could be subpoenaed
- Sessions and Interventions will need to be justified to a payer source

"What if, and I know this sounds kooky, we were transparent in our communications"

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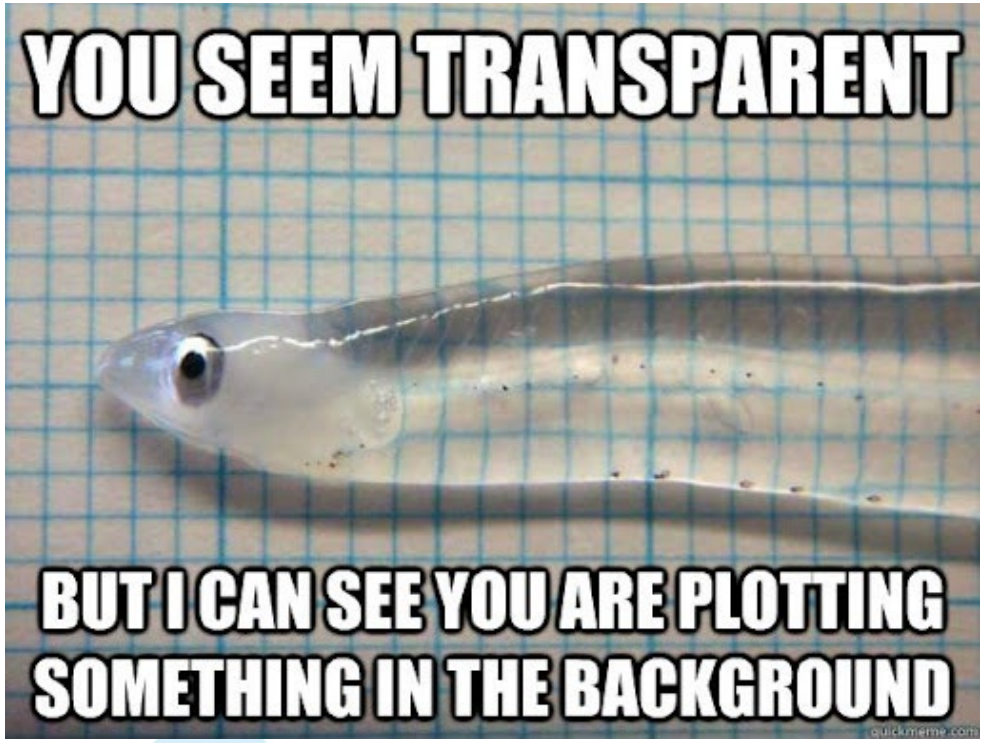
Research on Transparency



- Improve trust through increased transparency.
- Patients gained insights into their behaviors and cognitions more quickly.
- Therapist comfort level and skills influenced the adoption of a collaborative documentation process.
    - Di Carlo, Robert C. (2017) *Collaborative documentation in community behavioral health: The impact of shared record keeping of therapeutic alliance.* Doctoral thesis, Northern Arizona University.

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Improves Quality of Documentation

- **Improves compliance.**
- **Notes are:**
  - More timely
  - More accurate
  - More focused…promoting a link of assessment - treatment plan - and progress notes
- **Late documentation is poor documentation!**

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Deadlines and Productivity

"Whenever my staff come to me and say they are burned out and overwhelmed… I think to myself…I bet they quit doing collaborative documentation."

~ Virna Little

Improves Quality of Work-Life

- Documentation has become a bad word.
- Clinicians count on patients missing appointments to catch up.
- They schedule documentation time, which reduces patient's access to treatment…creates wait lists.
- Clinicians report that documentation competes with their time spent with patients.
- Working collaboratively is "Meaningful Documentation."

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Saves Time and Creates Capacity

- **Documentation becomes timely**, and consequently provides “value for risk-management.”
- **Increases clinician capacity** to see more patients and improves compliance.
- Transitioning from the Post Session Documentation Model to Collaborative Documentation Model can save from 6-8 hours per week for full time staff.
- Up to 20% increase in capacity!
  - Bill Schmelter PhD, Senior Clinical Consultant - MTM Services

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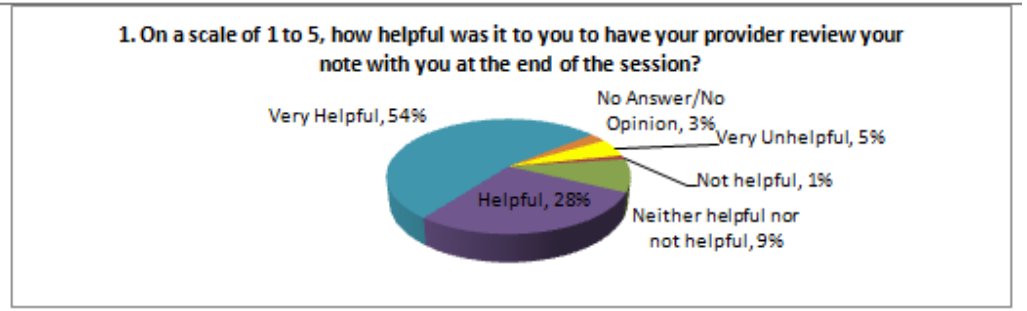
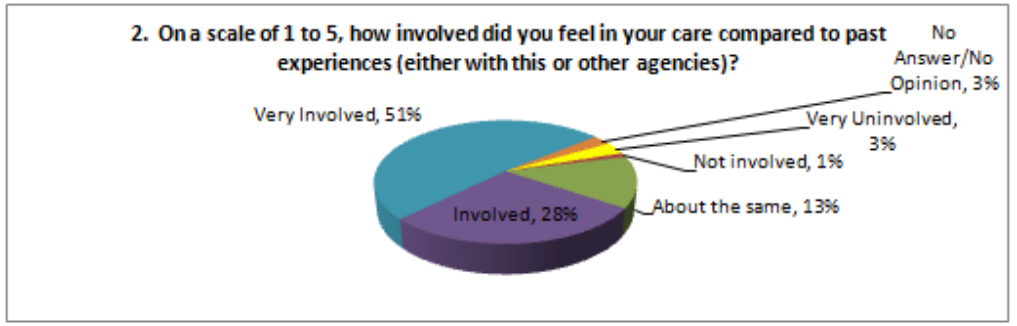
SAMHSA STUDY

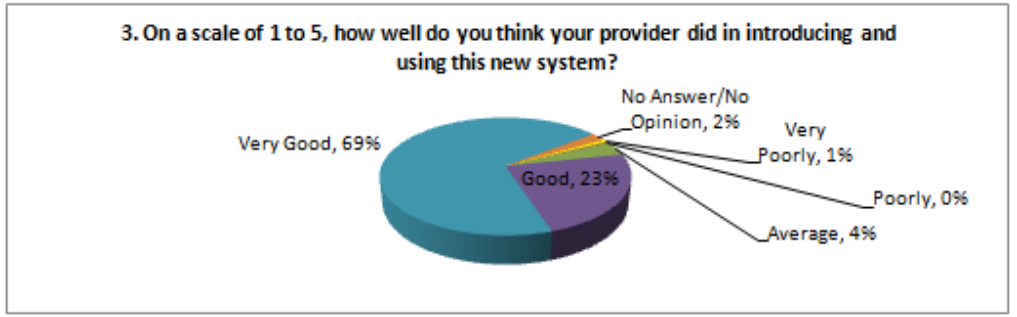
1. On a scale of 1 to 5, how helpful was it to you to have your provider review your note with you at the end of the session?	Percentages Total	Total %
1 Very Unhelpful	397	5%
2 Not helpful	93	1%
3 Neither helpful nor not helpful	726	9%
4 Helpful	2215	28%
5 Very Helpful	4218	54%
NA No Answer/No Opinion	204	3%
Total/Approval %:	7853	94%



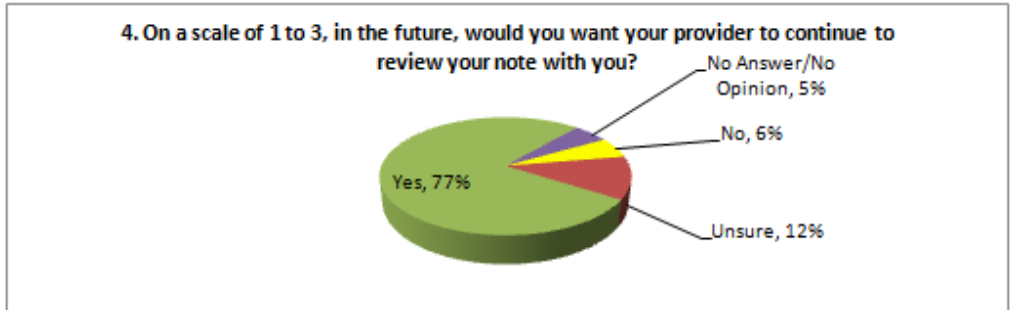
2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)?	Total	Total %
1 Very Uninvolved	222	3%
2 Not involved	76	1%
3 About the same	930	13%
4 Involved	1943	28%
5 Very Involved	3552	51%
NA No Answer/No Opinion	184	3%
Total/Approval %:	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%



You had me at...

SAVING TIME!

Setting Up the Space

- Face your patient
- This collaborative, doesn't have to be concurrent
- Avoid tables or desks between you and the patient

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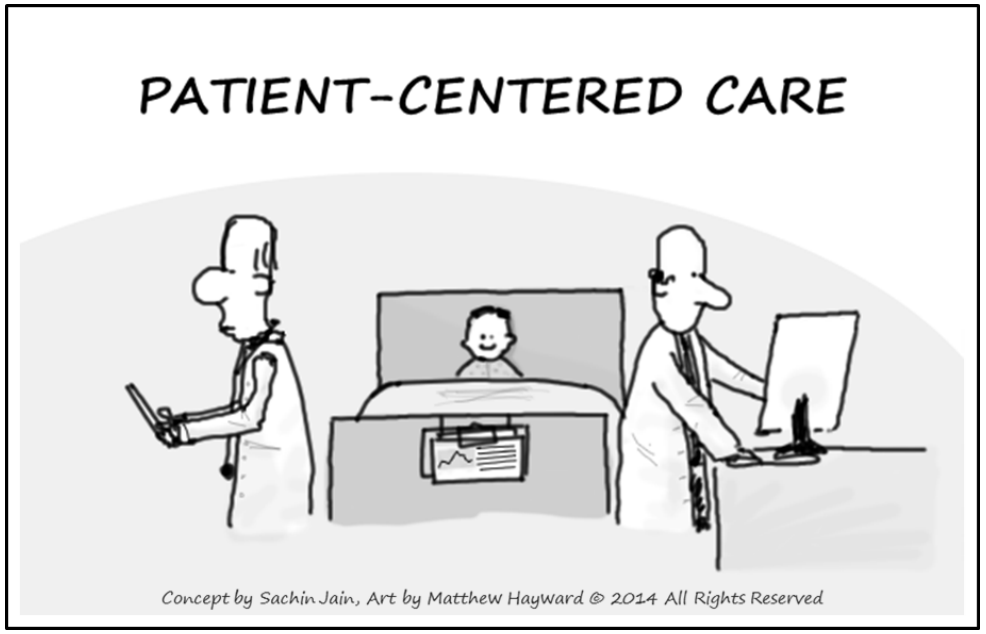
Introduce with a Script



- **“I’m just going to open your medical record to chart what we discussed today.”**
- **“I document in your chart the progress we make together and the goals we set. I will ask you to e-sign those goals at least every 90 days.”**
- **“Every appointment we will document during the last 5 minutes to make sure we are on the same page.”**
- **“I want to document what you are getting from our time together versus what I think you are getting.”**

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Sample Script-Trying Something New

"You know that after our appointments, I document what we discussed in your medical record. I've recently learned that it is helpful if we spend about 5 minutes at the end of the session documenting together as a team. It helps my understanding of what you are getting from services, what's helpful or not, and with us working together towards your goals.

From now on, at the end of our session, we will type a summary of the important things that we discussed today."

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Episodes of Care

1. Begins with an assessment that clearly identifies an appropriate clinical problem and corresponding diagnosis.
2. Next, the treatment plan should reflect a clear goal for helping the patient through the identified problem in the assessment.
3. The progress notes demonstrate that the services you deliver match what was prescribed in the treatment plan.
4. Each note should lead into the next, creating a comprehensive story of the client's progress through treatment.
5. The end of the Episode should be a Reoccurrence (Relapse) Prevention Plan.
6. This progression of documentation is required for compliance and reimbursement and an important tool for delivering quality care.

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Assessment

Goal: Establish qualification for services

- Symptoms
- Functional impairments/ consequences
- ICD-10 / DSM criteria – PHQ9 – AUDIT - GAD7, etc (symptoms, symptoms, symptoms)
- Identify strengths, challenges
- History – has person been diagnosed previously by another qualified provider?
- Identify assessed needs to be developed further in treatment plan

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Assessment Includes:

5) An assessment must include the following information in a narrative form to substantiate the member's diagnosis and must provide sufficient enough detail to individualize treatment plan goals and objectives:

(a) presenting problems and history of problem;

(b) family history (including substance use, social, religious/spiritual, medical, and psychiatric);

(c) developmental history (including pregnancy, developmental milestones, temperament);

(d) substance use and addictive behavior history;

(e) personal/social history (including school, work, peers, leisure, sexual activity, abuse, disruption of relationships, military service, financial resources, living arrangements, and religious and/or spiritual);

(f) legal history relevant to history of mental illness, substance use, and addictive behaviors (including guardianships, civil commitments, criminal mental health commitments, current criminal justice involvement, and prior criminal background

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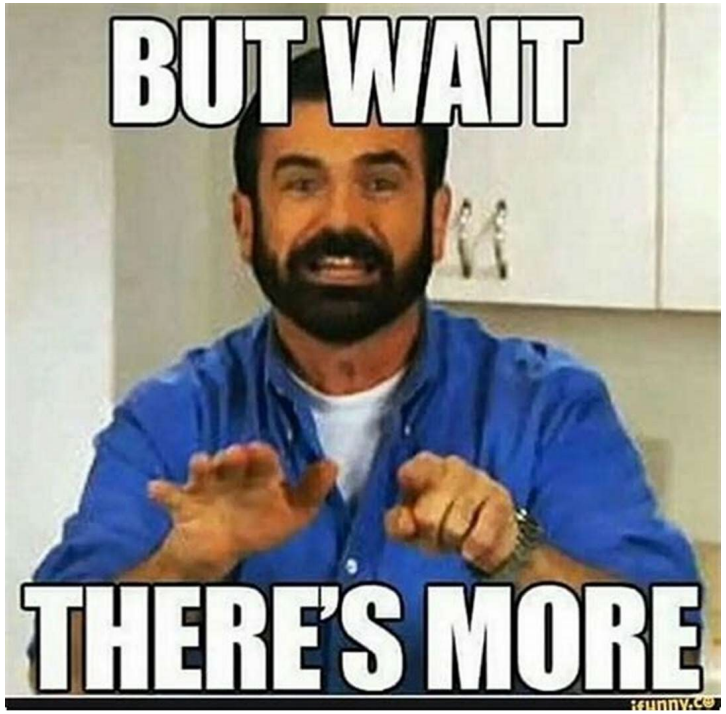
Assessment Includes:



(g) psychiatric history (including psychological symptoms, cognitive issues, and behavioral complications);

(h) medical history (including current and past problems, treatment, and medications)

(i) mental status examination (including memory and risk factors to include suicidal or homicidal ideation);

(j) physical examination (specifically focused on physical manifestations of withdrawal symptoms or chronic illnesses);

(k) diagnosis (diagnostic interview and impressions);

(l) survey of strengths, skills, and resources; and (m) treatment recommendations

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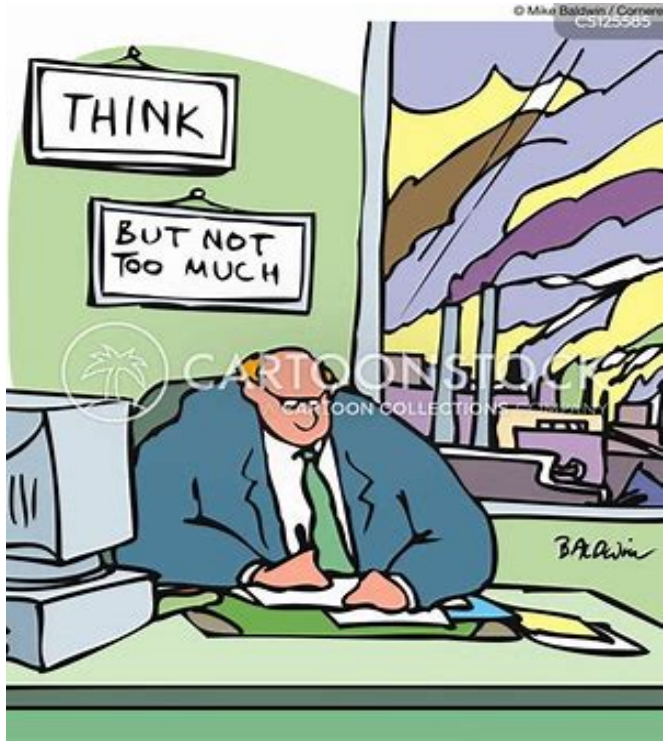
Diagnosis

Symptoms must support the diagnosis

Treatment Plan

- Establish a plan of what the patient would like to see improve and how you both will know that there is progress being made (or not).
- Keep it Simple!
- Use your screening tools (measurable).
- Make your EMR work for you!



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Treatment/Care Plan Elements

(a) The member's name, member's primary diagnosis and any other diagnoses that are relevant to the service(s) provided, the treatment plan date, and treatment plan review dates, if applicable;
(b) treatment team members who are involved with the member's treatment;
(c) individualized member strengths;
(d) the problems area(s) that will be the focus of the treatment, to include symptoms, behaviors, and/or functional impairments;
(e) treatment goals, objectives and interventions that are person centered and recovery oriented
(f) the description of the type, duration and frequency of the intervention(s) and service(s)
(g) include the member's level of functioning that will indicate when a service is no longer required.

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Review Regularly!

- Document the patient's response and progress in each note and review the goals each time you see the patient.
  - Minimum of every 90 days is required

- **Consider:**
  - How are you measuring progress?
  - Is the patient improving?
  - Are you changing/adjusting interventions in response to progress or lack of progress?

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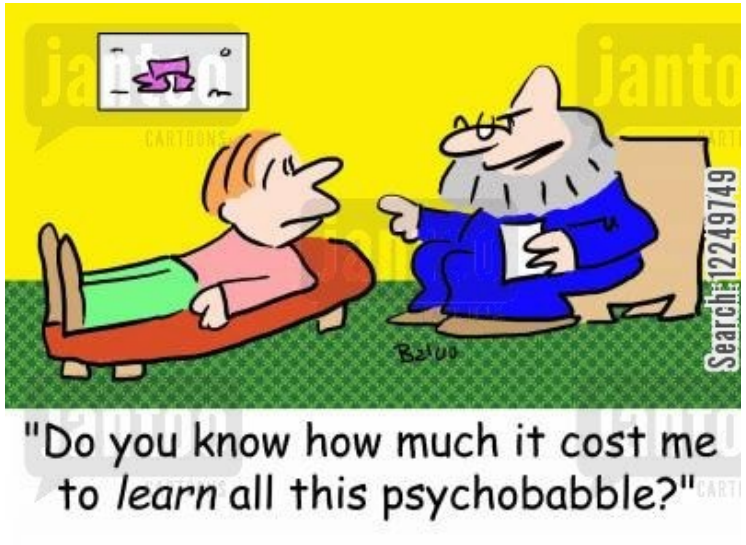
Progress Notes



- Must be tied to treatment plans in a meaningful way.
- Documentation of the interventions provided *and* how patient responded.
- Documentation of clinical progress and improvements.
- Readable – not "psychobabble."
- Address all assessed symptoms, deficits, and functional impairments resulting from the diagnosis.
- Demonstrates clinical necessity.
- Useful to:
  - Patient, clinician, anyone else involved in patient's care – team members, collaterals.

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Reoccurrence Prevention

- Ask Patient – What are the warning signs that symptoms are returning?
- What coping skills have been helpful?
- If your coping skills for whatever reason do not help and symptoms return, what do you do?

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Wrap Up

- Empowers the patient to give their perspective.
- Clinician and patient present and engaged in the process of the documentation.
- Common complaint that paperwork takes away from time spent with patient.
  - Saves time.
- Improves quality of work/life balance for clinicians.
- Helps with increasing performance demands.
  - Productivity and time constraints.
- Supports person-centered services.
- Data demonstrates that it can save 6-8 hours per week for full time staff.

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Questions?