

“Compliance, Medical Necessity, and Collaborative Concurrent Documentation”

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PLAN for the Session

- Compliance and Quality
- Medical Necessity and Documentation Linkage
- Strategies for Compliant, Person Driven, Outcome Focused Documentation that supports Collaborative Documentation
 - Assessment
 - Treatment/ Service Planning
 - Progress Notes
- Understanding the Value of Concurrent Documentation and Strategies for Incorporating it into Your Practice.
 - Benefits
 - Strategies

Compliance and Quality

What is Your Compliance Focus

- “Compliant Looking Paper” ?
- “Quality Service Processes” that meet the “Spirit of Standards” ?

Compliance and Quality

When We Focus on Paper Compliance

Clinical Staff come to not just devalue documentation but also to de-value the clinical processes they represent:

- The Assessment Process
- The Service Planning Process
- The Value of the Service Plan for their Work with Clients

Don't let the Compliance "Tail" Wag the Quality "Dog"

Compliance and Quality

As we make organizational and process changes necessary to accommodate the need for faster access and more efficient services ...

...we must to remember that our “Value” to clients and to payers under healthcare reform will be measured by our ability to produce “Positive Outcomes” and reduce the use of unnecessary disruptive and high cost services!

Worthwhile Documentation

Documentation Models Should Support:

- Compliance
- Outcome Oriented – Person Centered Services
- Efficiency

Compliance

The Big Three

- Medical Necessity
- Client Participation
- Client Benefit

Medical Necessity

Medical Necessity Phase 1:

- Establish that an individual seeking behavioral health services is qualified to receive specific services at a particular level of care and/or intensity.
 - Qualifying DSM-IV diagnosis of a mental, behavioral, or emotional disorder
 - Diagnosed within the past year by a qualified practitioner
 - Results in functional impairment which substantially interferes with or limits the person's daily life activities.

Medical Necessity

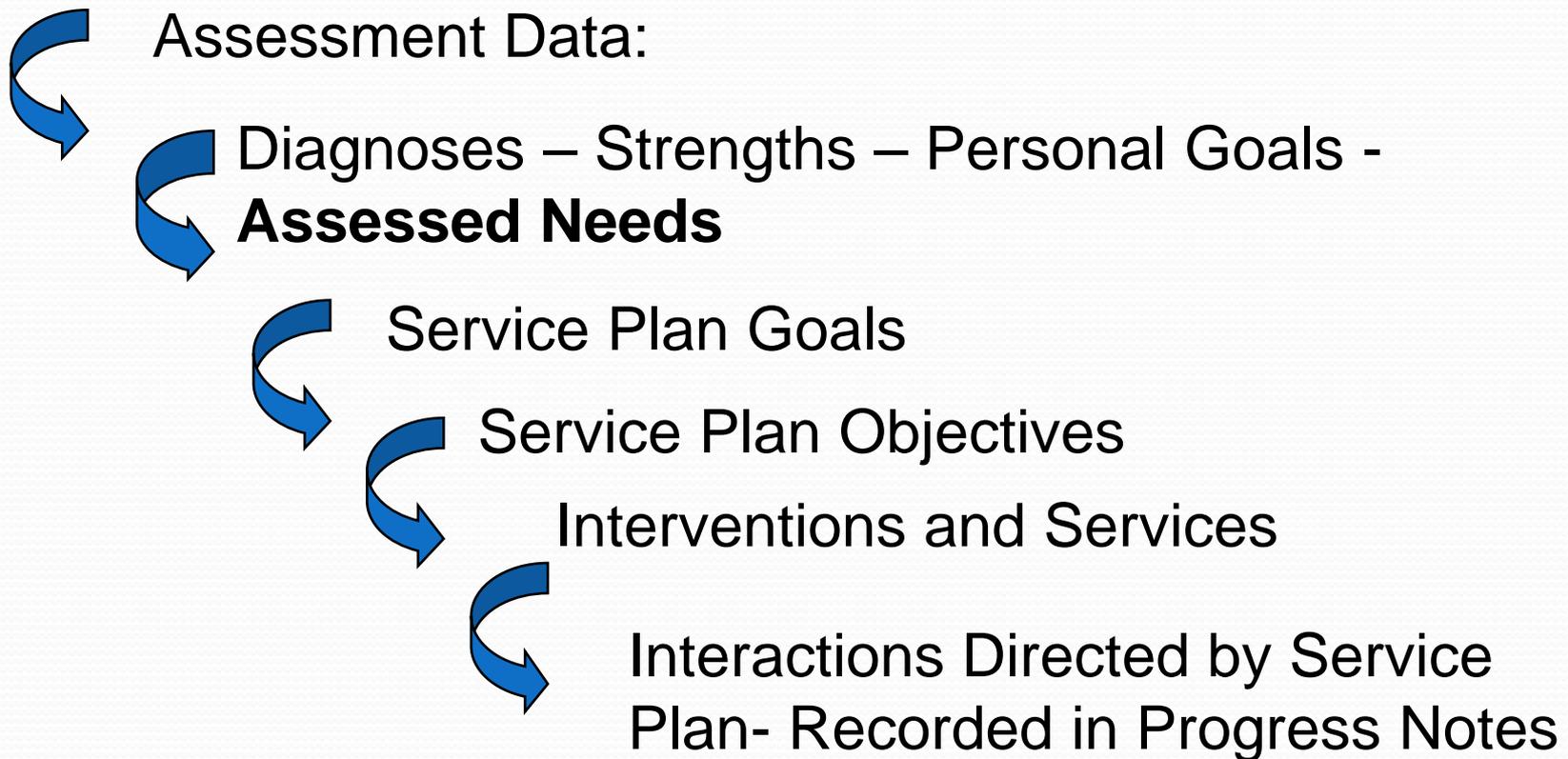
Medical Necessity Phase 2:

- Establish that ***all services and interventions*** provided are necessary and potentially sufficient to:
 - Address assessed needs in the areas of symptoms, behaviors, functional deficits, and/or other deficits/barriers directly related to or resulting from the diagnosed behavioral health disorder
 - Produce improvements or prevent worsening

Medical Necessity

- **Decide if you'd pay for that!**
 - Every Progress Note is a bill for services.
 - Would you pay for what you read in a progress note?
 - We get paid to provide skilled interventions that address assessed BH needs and help a person reach personal life goals .
 - We don't get paid to "see clients" or for 'conversations that meander with the client'

Medical Necessity and the Golden Thread



Person Centered Services

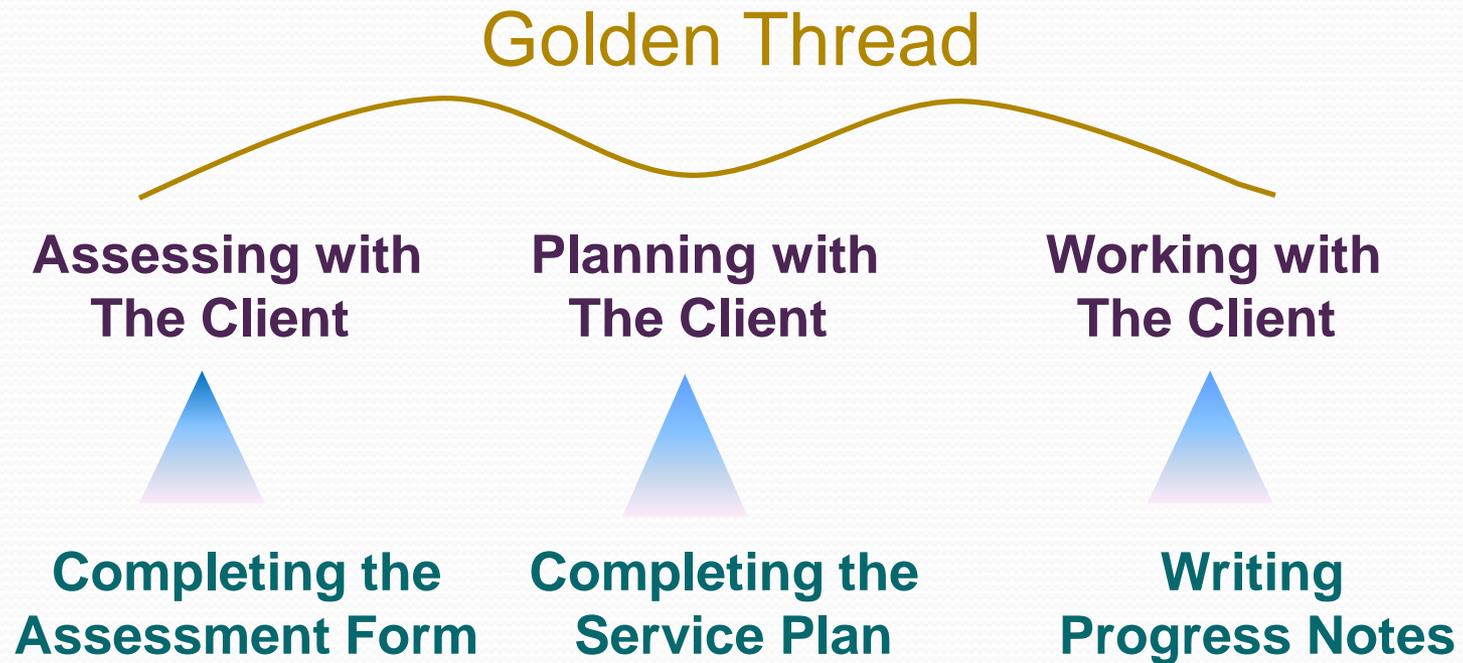
Person Centered Services:

- Focus on the person / family in the context of their personal/ life goals , individual strengths, unique barriers, etc.

Person Driven Services:

- Involving the individual/ family in directing the plan of care (developing, reviewing, updating service planning)

Where is the Golden Thread ?



Golden Thread Shadow - Documentation Linkage

Person Centered Services

Person Centeredness is Often Inserted at the Wrong Point in the Clinical Process.

- Starting at the Service Planning Process - With Questions like “What would you like to work on?” “What Goals do you have for treatment?” (This ignores the assessed needs identified in the assessment process”)
- In therapeutic sessions where discussions routinely focus around whatever the client wants to discuss rather than working on the mutually developed service plan. (If the plan isn't relevant – change it!)

Documentation Strategies That Support Worthwhile Documentation

Assessment

The customer of the Assessment is whoever is developing the Treatment Plan

They Need:

-

Assessment

The customer of the Assessment is whoever is developing the Treatment Plan

They Need:

- Clearly identified and prioritized Behavioral Health Needs (Challenge Areas) that can be used to establish Goals.

Examples of Identified Need Areas

- Symptoms
 - Mental Health
 - Substance Abuse
- Behaviors
- Functional/ Skill Deficits (ADL/Self Care and Life Skills)
- Supports Deficits
- Service Coordination Needs
- Other Identified Needs

Assessment

Sample Assessment Section Identified Needs and Service Recommendations

#	Identified Need	Recommended Services	A __ D__ R__

Person's Name (First MI Last): [REDACTED]		Record #: [REDACTED]			
Prioritized Assessed Needs: A-Active, PD-Person Declined, D-Deferred, R-Referred Out (If declined/deferred/referred out, please provide rationale)		A	PD*	D*	R*
1.	[REDACTED]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	[REDACTED]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	[REDACTED]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	[REDACTED]	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	[REDACTED]	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	[REDACTED]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Person Declined/Deferred/Referred Out Rationale(s) (Explain why Person Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out below). [REDACTED] <input type="checkbox"/> None					
1.	[REDACTED]				
2.	[REDACTED]				
3.	[REDACTED]				

Level of Care/Indicated Services Recommendation: [REDACTED]

Person Served/Guardian/Family Response To Recommendations: [REDACTED]

Assessment

The customer of the Assessment is whoever is developing the Treatment Plan

They Need:

- Clearly identified and prioritized Behavioral Health Need/ Challenge areas that can be used to establish Goals
- Symptoms, Behaviors, Skill and Functional Deficits stated as 'baselines' whenever possible in order to develop objectives.
-

Assessment

The customer of the Assessment is whoever is developing the Treatment Plan

They Need:

- Clearly identified and prioritized Behavioral Health Need/ Challenge areas that can be used to establish Goals
- Symptoms, Behaviors, Skill and Functional Deficits stated as 'baselines' whenever possible in order to develop objectives.
- Client Strengths , Preferences , and Personal/ Life Goals that will be useful in developing service plan Gs and Os and in supporting change

Person Centered Services

Personal Life Goals and Aspirations

Do We Ask The Question?

Personal Life Goals

When You Ask the Question!

- “Get my GED and work in medical transcription.”
- “Have less stress related to parenting”
- “Take care of my kids & get back into church.”
- “Spend time with my grandchildren unsupervised.”
- “Going back to school and working.”
- “To maintain positive relationship with parents and siblings.”
- “Be able to talk to sister without getting upset or mad”
- “Be able to socialize and make friends”
- “Be able to live on my own”

Service Planning

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 (clinician and client) want the outcome of our work together to be, as we address this identified need?”**

Service Planning

Examples of goals:

- “Maria wants her son Jason to be able to focus and follow directions”
- “Ben wants to stop getting into trouble in school and at home”
- “John states he just wants to feel normal”
- “Gwen states she wants to learn how to take care of herself and live on her own”

For an involuntary/ non-engaged client.

- “Robert will recognize the negative effects Substance Use is having on his life and voluntarily participate in recovery services”

Service Planning

Goals

- Incorporate personal goals when possible with behavioral health goals

Service Planning

Examples of goals:

- “Maria wants her son Jason to be able to focus and follow directions **so he can do better in school and make friends and to reduce her stress.**”
- “Ben states he wants to stop getting into trouble in school and at home” **so he can stop getting grounded and spend time with his friends**
- “John states he wants to feel normal **so he can get a job and have friends**”

Service Planning

Objectives

Definition:

- Objectives are observable, measurable, **changes in symptoms, behaviors, functioning, skills, knowledge, support level.etc** that relate to achievement of the goal, **and are expected to result from planned interventions.**
- The Assessment should identify the baseline levels of symptoms, functional/ skill deficits and behaviors that constitute the basis for the identified needs. Objectives are stated changes in these baselines.

Service Planning

Think of Objectives as “milestones” not as things a client will do!

Three Kinds of Changes from Baseline:

- 1. Changes in Level of Understanding of an Identified Need**
- 2. Changes in Competencies, Skills, Information**
- 3. Changes in Behaviors, Functioning, Symptoms, Conditions (e.g. level of Supports)**

Service Planning

Examples of Objectives:

- “Steven and the clinician will understand the chief causes of Steven’s Panic Attacks”
- “Jordan will be able to articulate and demonstrate 3 strategies for reducing symptoms of depression.”
- **“Jordan will engage in productive and/or leisure activities outside the home at least twice a week.”**
- “David will be able to identify situations that make him frustrated/ angry in school and will be able to articulate and demonstrate 2 strategies for appropriately dealing with them.
- **“David will reduce verbally aggressive outbursts in class from 3 or more times daily to once or less weekly.”**
- “Client’s mother will learn and implement 3 key strategies for dealing with Jason’s oppositional behaviors.”
- **“John’s will follow his mother’s directions with only one follow-up prompt 70 percent of the time.**

Service Planning

Objectives

- Attempt to develop a measurable change that:
 - Will be apparent to the client
 - Meaningful to the client
 - Achievable in a reasonable amount of time
 - Can be assessed in a nonjudgmental way
- Discuss the relationship of the desired change to achieving the behavioral health goal and personal life goal(s)

Measuring Objectives

- Some Objectives are easy to measure and for the client or family to report on.
 - Articulation and demonstration of skills/strategies
 - Demonstration of knowledge
- Some Objectives are better assessed with the use of self tracking tools or scales:
 - Symptoms
 - Behavioral changes
- You don't want to just be measuring the client's latest experience today or yesterday.

Service Plan Goals and Objectives

Electronic Health Records

- Carefully evaluate the use of “Dropdowns” for Goals and Objectives
- These are intended to be individualized
- Difficult to have a meaningful discussion about Goal and Objective development using dropdowns .
- I recommend not using dropdowns for Goals and Objectives!

Service Planning

Interventions (Methods)

Definition:

An intervention is a clinical strategy or type of action that will be employed within a Service type (modality) and is expected to help achieve an Objective.

Interventions briefly describe what approach, strategy and/or actions the Treatment Plan is prescribing.

Service Planning

Examples of Interventions:

- “Explore with client the reasons for his/her panic attacks”
- “Help the client identify triggers for his anger and strategies to for avoiding these triggers or responding differently”
- “Teach client meal planning, shopping, and meal preparation skills”
- “Use CBT to help client change destructive irrational believes that lead to feelings of guilt”
- Teach the client about benefits of medication, coping with side effects”
- “Pharmacological treatment for X symptoms”
- “DBT” (When an intervention strategy is very well articulated, has defined steps and outcomes, it may not be necessary to do more then indicate the type of intervention strategy with some key elements that are understandable to the client.)

Service Planning

Services

Definition:

Services are the modalities or formats in which interventions are provided.

Service Planning

Examples of services:

- Individual/ Family Therapy
- Group Therapy/Counseling
- Case Management
- Community Support
- Psychosocial Rehabilitation
- Medication Monitoring

Sample

Goal, Objective, Interventions, Services, Frequency and Provider Type

Goal 2: (Based on Assessed Need #___) Client States he wants to feel less depressed so he can go back to work and have a social life again.

Objective a: Client will experience at least 3 days per week where he feels well enough to leave his residence and engage in a chosen productive or leisure activity.

Interventions	Services	Frequency/ duration	Provider type
Pharmacological treatment for depressive symptoms	Med Management	2X month for 60 days then 1X month	Psychiatrist
CBT to help client identify destructive irrational beliefs that result in severe feelings of guilt	Individual Therapy	1X week 1 hr	LCSW
Education and support for coping with depression	Group Therapy	1X week 1 hr	LCSW

Sample Massachusetts Plan Format

Goal #: _____			
Linked to Assessed Need # _____ from form dated _____ : <input type="checkbox"/> CA <input type="checkbox"/> CA Update <input type="checkbox"/> Psych Eval. <input type="checkbox"/> Other: _____		Start Date: _____	Target Completion Date: _____
Desired Outcomes for this Assessed Need in Person's Words: _____			
Goal (State Goal Below in Collaboration with the Person Served/Reframe Desired Outcomes): _____			
Person's Strengths and Skills and How They Will be Used to Meet This Goal: _____			
Supports and Resources Needed to Meet This Goal: _____			
Potential Barriers to Meeting This Goal: _____			
OBJECTIVE # _____ :			
Person Served Will: _____			Start Date: _____
Parent/Guardian/Community/Other Will: (<input type="checkbox"/> Not Clinically Indicated) _____			Target Completion Date: _____
Intervention(s)/ Method(s)	Service Description/ Modality	Frequency	Responsible: (Type of Provider)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Interaction/ Progress Notes

Importance of Service Plan Awareness !

- Be Aware of the Service Plan BEFORE the session and know what Goal(s) Objectives you plan to work on with client.
- Your plan may need to change but you should have a plan.
- Focusing on the Service Plan reinforces the value of the plan.
- If the plan becomes irrelevant – change it.

Interventions/ Interactions

How are You Doing?

- When you ask “How are you doing?” people will generally answer the question “How is the world treating you”
- This can often move the focus of a session to a discussion of recent events, mini crises, etc. (meandering with the client)
- By preparing for interventions you can keep the focus on “How are you Doing?” (e.g. “How are you applying what you’ve learned to this new situation)
- This will focus the session and result in progress notes that link to the treatment plan

Interaction/Progress Notes

1. New, salient information provided by client.
2. Changes in mental status
3. Goal(s) and Objective(s) that were focused on
4. Interventions , work done.
5. Client's response to intervention (today)
6. Client's progress re the Goal/ objective being addressed
7. Plan for continuing work

Interaction/Progress Notes



Psychotherapy Progress Note
Revision Date: 3-7-09

Person's Name (First / MI / Last): <input type="text"/>		Record #: <input type="text"/>	DOB: <input type="text"/>
Organization Name: <input type="text"/>			
Modality	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Couple		
List Names of Persons Present	<input type="checkbox"/> Person Present <input type="checkbox"/> Person No Show <input type="checkbox"/> Person Cancelled <input type="checkbox"/> Provider Cancelled Explanation: <input type="text"/> <input type="checkbox"/> Others Present (please identify name(s) and relationship(s) to Person): <input type="text"/>		
Person's report of progress towards goals /objectives since last session: <input type="text"/>			
New Issue(s) Presented today: <input type="checkbox"/> None Reported <input type="checkbox"/> New Issue resolved, no CA required <input type="checkbox"/> CA Update Required <input type="text"/>			
Person's Condition	No Significant Changes Reported or Observed	Notable	Changes in Person's Condition
Mood/Affect:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Thought Process/Orientation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Behavior/Functioning:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Medical Condition:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Substance Use: <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Risk Assessment			
Danger To: <input type="checkbox"/> None OR Check all that apply below and record action taken in Therapeutic Interventions section below			
<input type="checkbox"/> Self:	<input type="checkbox"/> Ideation	<input type="checkbox"/> Plan	<input type="checkbox"/> Intent <input type="checkbox"/> Attempt - Comments: <input type="text"/>
<input type="checkbox"/> Others:	<input type="checkbox"/> Ideation	<input type="checkbox"/> Plan	<input type="checkbox"/> Intent <input type="checkbox"/> Attempt / <input type="checkbox"/> Property: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Attempt



Interaction/Progress Notes

Goal(s) Addressed as Per Individualized Action Plan:

- Goal
- Objective 1
- Objective 2
- Objective 3
- Objective

- Goal
- Objective 1
- Objective 2
- Objective 3
- Objective

Therapeutic Interventions Delivered in Session:

Person's Response to Intervention/Progress Toward Goals and Objectives:

Plan / Additional Information (*Indicate action plan between sessions*):

Collaborative Documentation

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Collaborative Documentation

What is Collaborative (Concurrent) Documentation?

- **Collaborative Documentation** often referred to as **Concurrent Documentation**, is a process in which clinicians and clients collaborate in the documentation of the Assessment, Service Planning, and ongoing Client-Practitioner Interactions (Progress Notes).
- **The Client must be present and *engaged* in the process of documentation development.**

Collaborative Documentation

Appropriate for use:

- Assessment
- Assessment Updates
- Service Planning, Diagnostic and
- Service Plan Updates
- Progress Notes – Office Based or in Community
- Individual & Group

Collaborative Documentation:

You can collaboratively document well or poorly!

- CD can be done in a way that clients and families will like or in a way that makes them resentful.
- Collaborative Documentation **will** save you time – but – it can also
 - Improve compliance
 - Improve client engagement and client involvement
 - Help focus clinical work

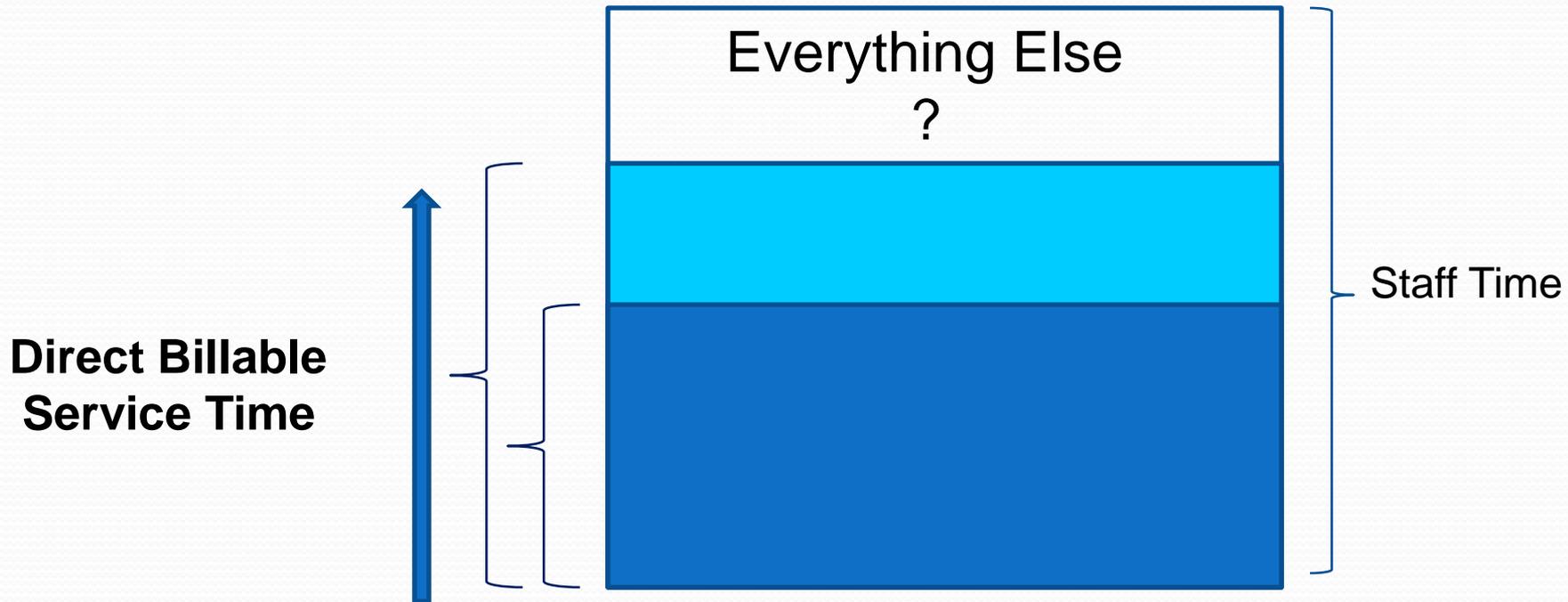
Collaborative Documentation

Benefits:

- Creates Staff Capacity
- Improves staff quality of work life
- Supports person centered and person driven services
- Supports compliance

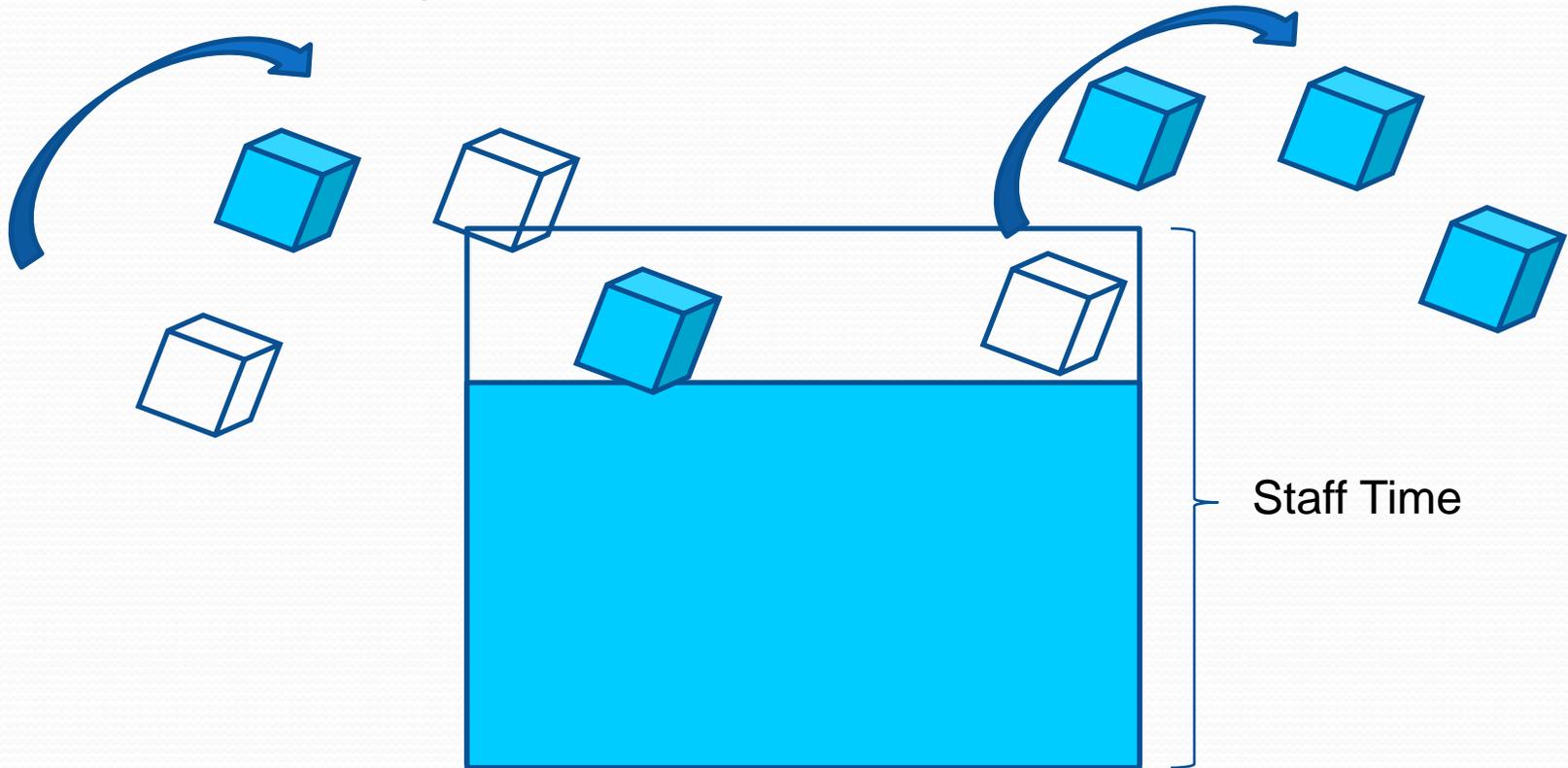
Something's Gotta Give!

↑ **Emphasis on Compliance, Person Centered Services, Clinical Quality & Performance Standards**



Something's Gotta Give!

↑ **Emphasis on Compliance, Person Centered Services, Clinical Quality & Performance Standards**



Who Decides What Stays in the Box ?

Collaborative Documentation

Collaborative Documentation takes a significant amount of documentation time out of the box ...

And

Improves compliance and service quality!

Collaborative Documentation

- **Most Common Reasons for Resistance**
- It can't happen here! (Terminal Uniqueness)
- It will interfere with the therapist/ client relationship.
- It's not fair to clients.

CD and Therapist/ Client Relationship

Factors that impact the therapist/client relationship

- Staff Time /Stress Level (time for clients)
- Rapport /Trust (are we listening?)
- Person Centered (maintaining relationship between person life goals, assessed needs, service plan goals, and interventions)
- Person Directed (Client/Family actively participates in directing their course of treatment.)

Effect of Direct Service to Documentation Ratio on Performance and Available Time

Using a 40 hr week and a 100 hour per month direct service standard:

Dir Hrs	Doc Hrs	Max Dir hrs/wk	Max Dir hrs/mo	Time for all else (hrs /mo) (If meet standard)
1	2	13.3	53.2 (53.2% of Standard)	0
1	1	20	80 (80 % of Standard)	0
2	1	26.6	106.4 (106.4% of Standard)	10-hrs (3 weeks/yr)
3	1	30	120 (120% of Standard)	26.8-hrs (8 weeks/yr)
4	1	32	128 (128% of Standard)	35-hrs (10.5 weeks/yr)

CD vs. Post Session Documentation

Time Savings

- Transitioning from Post Session Documentation Model to Collaborative Documentation Model can save from 7 – 9 hours per week for full time staff.

Mid Western Colorado: Benefits of Concurrent Documentation

To MHC Staff:

- Can save up to 8 hours per week (or 384 hours per year) in documentation time.
- With increased time availability, this allows clinicians to be less anxious about accepting and seeing more consumers on their caseload at any one time.
- Conversion to CD is accompanied by a drop of up to 25% in staff sick time usage
- Less anxiety and stress to direct service staff would result in enhanced morale greater job satisfaction, and improved quality of life/sense of well-being.

Metropolitan's Concurrent Documentation Pilot Outcomes

Metropolitan provided a pre-post evaluation of a 6 week concurrent documentation pilot. The results were:

- Pilot therapists rate quality of the working alliance with clients equal to therapists in the control group.
- Pilot client/therapist pairs show almost identical levels of agreement with client/therapist control group pairs regarding working alliance
- On average pilot therapists spent 9 fewer post session hours on paperwork **per week** than control group therapists.

CD vs. Post Session Documentation

Quality of Work Life

- Collaborative Documentation eliminates:
 - Documentation treadmill (always catching up)
 - Hoping for No/Shows to complete paperwork
 - Separation of paper process from clinical process (creating documentation irrelevance)

CD vs. Post Session Documentation

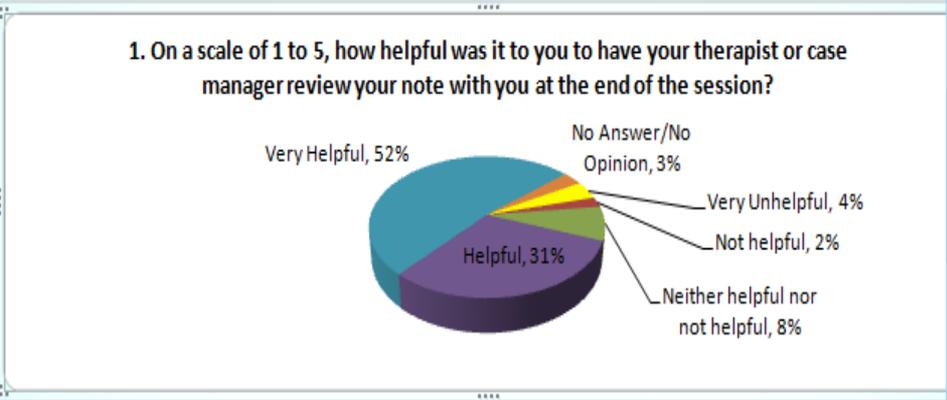
It's Not fair to Clients!

MHC of Greater Manchester Concurrent Documentation Case Study

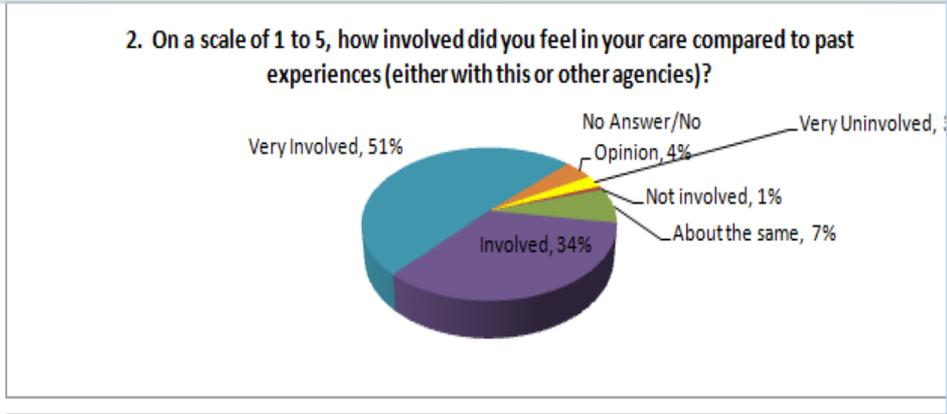
- **Client Satisfaction Results:**
- 927 Clients Responded
 - 83.9% felt the practice was helpful
 - 13.7% found it neutral
 - 2.3% disagree that it is helpful

Chart 2

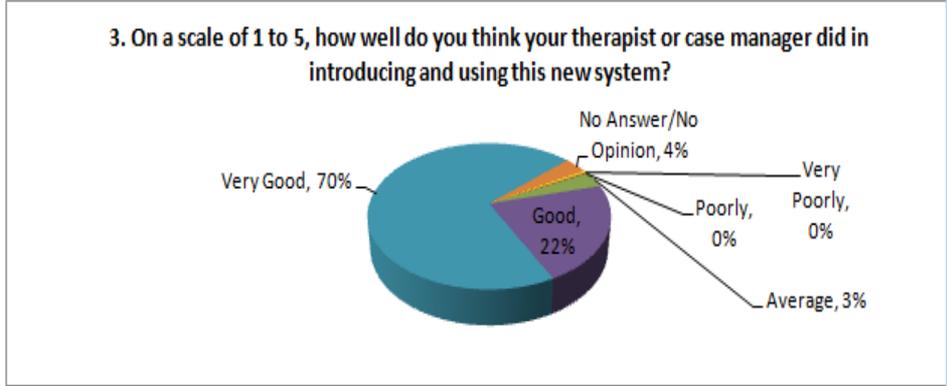
1. On a scale of 1 to 5, how helpful was it to you to have your therapist or case manager review your note with you at the end of the session?		Percentages	
		Total	Total %
1	Very Unhelpful	25	4%
2	Not helpful	14	2%
3	Neither helpful nor not helpful	47	8%
4	Helpful	186	31%
5	Very Helpful	317	52%
NA	No Answer/No Opinion	19	3%
Total/Approval %:		608	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	16	3%
2	Not involved	5	1%
3	About the same	45	7%
4	Involved	207	34%
5	Very Involved	309	51%
NA	No Answer/No Opinion	26	4%
Total/Approval %:		608	97%



3. On a scale of 1 to 5, how well do you think your therapist or case manager did in introducing and using this new system?		Total	Total %
1	Very Poorly	2	0%
2	Poorly	2	0%
3	Average	20	3%
4	Good	125	22%
5	Very Good	405	70%
NA	No Answer/No Opinion	21	4%
Total/Approval %:		575	99%



Comment by ACT Client Sums it Up

Really enjoy doing the notes with clinician because it reminds me of sticking to my goals

Concurrent Documentation Case Study Notes

By: John Kern, MD, Medical Director
Southlake Mental Health Center

Client acceptance – Though there has been concern that clients would perceive concurrent documentation as intrusive and impersonal, our experience has been far from this. Some clients have told our staff that they think what they are saying must be important if it is being written down. I am frequently prompted to include information in my notes as I am typing, “Make sure you also say so-and-so.” One of our pilot outpatient clinicians told us that clients wanted her to bring the computer back after the pilot was over. I have personally not had a single complaint after thousands of sessions.



Collaborative Documentation

Implementation Strategies

Collaborative Documentation

Keys to Successful Collaborative Documentation Implementation

- Attitude (clinician/ organization)
- Preparation
- CQI Approach

Concurrent Documentation

The 7% Percent Factor

- There are situations where concurrent documentation is not appropriate
- 93% of the time concurrent documentation is appropriate, positive and helpful.
- Failures to implement are often due to a focus on the 7%

Clinician Attitude

- View collaborative documentation as an essential element of the therapeutic process that you are learning to integrate into and consistently use in all of your direct service sessions.
- If you project CD as a valuable interactive process, your clients will perceive it this way also.
- Setting routine is one of the best ways to get into habit.
- Implementation experience shows that collaborative documentation will become a habit within 6 weeks.

Developing “Scripts” to Introduce Collaborative documentation

Collaborative Documentation

Sample Introductory Script for Existing Clients

“As you know I normally write notes about our sessions afterward in my office. We now believe that there is value in making sure that you contribute to what is written in your notes. Also, I want to be sure that what I write is correct and that we both understand what was important about our sessions.”

“So from now on at the end of the session we will work together to write a summary of the important things we discuss”

Collaborative Documentation

Sample Introductory Script for New Clients

“Here at (agency name) we believe that there’s value in making sure that you contribute to what is written in the notes about our sessions with you. Also, I want to be sure that what I write is correct and that we both understand what was important about our sessions.”

“So at the end of the session we will work together to write a summary of the important things we discuss”

Collaborative Documentation

Then explain the kinds of things that will be documented:

- Important information presented by the client
- The Goals and Objectives worked on
- The interventions provided/ work done during the session
- The client's response to the session today
- Progress toward the Goal(s) Objective(s)
- Any plans or next steps

Mid Western Colorado: Sample Script

A Program Supervisor in Mid Western Colorado uses this script with consumer/families:

“Because this record is your record, and in an attempt to build therapeutic trust, we will develop a note at the end of our session that describes what we talked about during this session. This note needs to include a description of what we discussed and did during the session. I will include my assessment, but if you have either support or disagreement with what I write let me know and I will include your comments. We could also discuss any agreements or disagreements you have, to help clarify issues. It is important for you to speak up with your idea and opinions. We will also place in the note any plans we develop for the next meeting and any homework you or I need to do to help with your treatment.”

Mid Western Colorado: Concurrent Documentation Guidelines

Some introductory phrases to transition into documenting the service might be

- *“Now let’s work together to document the important accomplishments/ideas/work that we have done today.”*
- *“What you shared is important. I want to capture this information.”*

Collaborative Documentation: Intake/ Assessment

Know your assessment instrument !

Option 1 (Preferred)

- Take one content section at a time
 - Presenting Problem
 - Psychiatric Hx
 - Family Hx, etc....
- Discuss the section with the client/ family
- Enter into system allowing client to see and comment/clarify

Option 2

- Sit with client and complete assessment item by item allowing client to see and comment/clarify

Collaborative Documentation: Intake/ Assessment

Know your assessment instrument

Diagnoses:

- Talk with client about what diagnoses really are and then share your current conclusions and document with client.

Interpretative/Clinical Summary

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

Identified Needs/ Challenges

- 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:

- Start with discussing previously identified current need/challenge areas
- Select one identified need/ challenge area and ask, “What do we want the outcome to be as we work on this issue? Discuss and enter a collaborative statement.
- Ask “if we accomplished that what would you have or be able to do that you can’t now/” (i.e. personal goals)? Or “I know you said you’d like to live on your own. Would achieving this goal help you to do that?” Then add this to the goal statement as discussed earlier.

Collaborative Documentation: Treatment (Service) Plan

Objectives:

- For the identified goal identify one or two objectives with client that are changes in baseline in either: an understanding of a problem, competencies, skills, information – OR – **behaviors, symptoms, conditions**. Document with client and discuss how the objective will be measured (how will we know when we get there)

Interventions and Services

- Discuss the Intervention(s)/ Strategy(s) that will be used to help achieve the objective. Document with the client.
- Indicate the modality/service that the intervention(s) will be provided in as well as the planned frequency and duration

Collaborative Documentation: Progress Notes (Therapy Sessions)

- Interact normally with the client during session taking notes on pad saying “I’m going to jot down some notes so we’ll remember them when we write our note at the end of the session”.
- At end of session (Time usually used for “Wrap Up”) say “Lets review and write down the important parts of our session today.”

Collaborative Documentation: Progress Notes

Separate the discussion into brief talking points:

1. New salient information provided by client.
2. Changes in Mental Status
3. Goal(s) and Objective(s) that were focused on
4. Interventions (what did we do to help reach the objective)
5. Client's response to intervention (today)
6. Client's progress re the Goal/ objective being addressed
7. Plan for continuing work

Collaborative Documentation: Progress Notes (Medication Management)

Option 1.

- Some prescribers like to do CD very much the way described for therapy sessions.
- Meet with the client as usual then say “OK – lets write down the important parts of our session today”

Collaborative Documentation: Progress Notes (Medication Management)

Option 1. (Continued)

Recommended Conversation Points:

- Interim History (Information reported by the client)
- Mental Status
- Adherence / Side Effects / Allergies, etc
- Interventions provided (usually checkbox)
- Goals/ Objectives addressed
- Client Response to Interventions (Today)
- Progress on Goals, Objectives
- Med Changes
- Any other Plans - Recommendations

Collaborative Documentation: Progress Notes (Medication Management)

Option 2.

- Some prescribers like to split Medication Management sessions into 2 or three conversations and then document at end of each section.

Collaborative Documentation: Progress Notes (Medication Management)

Option 2. (Continued)

Example of Topic Area Breakdown:

- Interim History (Information reported by the client)
- Mental Status
- Adherence / Side Effects / Allergies, etc
- Interventions provided (usually checkbox)
- Goals/ Objectives addressed
- Client Response to Interventions (Today)
- Progress on Goals, Objectives
- Summary of Med Changes
- Any other Plans - Recommendations

Common Questions

- What if the client says “I don’t want to document during the session” ?
- How do I use CD with young children?
- How do I use CD in family therapy?
- When shouldn’t I use CD?
- What if I need to document something I don’t want the client to see?
- How do I document clinical interventions/interpretations in a way that is understandable to the client but is also clinically relevant and compliant?

Common Questions

- How do I do CD in Groups?
- How do I do CD in the community or in people's homes.
- What if a client is too cognitively impaired to participate in CD?
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Questions?