Collaborative Documentation with Children & Youth: Getting the Tools to Work for You

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My Transition to Collaborative Documentation

Why I am Here Today

> I stopped needing to work nights and weekends

> My documentation improved as it became a true reflection of the treatment session

> The documentation became valuable

> Clients engagement in treatment improved

> Productivity exceeded expectations

> MY QUALITY OF LIFE IMPROVED
Historical Documentation Challenges

> Documentation has Become “The ENEMY”

> Clinicians report that documentation competes with time spent with clients

> Clinicians count on “no-shows” to complete paperwork and catch up

> High documentation to direct service ratio reduces number of scheduled appointments in clinic and in community (negatively impacts service capacity)

> Clinician’s paperwork is divorced from their clinical work.

> Clinician’s quality of life is affected!
Collaborative Documentation – What is it?

> Collaborative Documentation is a process in which clinicians and clients collaborate in the documentation of the Assessment, Service Plan, and Progress Notes.

> 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 clinicians to clarify their understanding of important issues and focus on outcomes.

> The Client must be present and engaged in the process of documentation development.
Collaborative Documentation – Benefits!

> Improves client engagement and involvement

> Helps focus clinical work on change and outcomes

> Improves compliance

> Saves time and creates capacity

> Improves quality of life of clinicians
Common Concerns of Clinical Staff

- “It’s not fair to clients – they will resent doing paperwork!”
- “Collaborative documentation takes away from treatment.”
- “There is no way to complete a progress note, treatment plan, or assessment with a client.”
- “There are no clinical benefits to completing the documents with clients, especially children, paranoid and psychotic clients.”
- “I need time to think about what I want to write before I complete a note.”
- “You cannot complete documentation collaboratively during a crisis situation.”
Remedy for High Documentation to Direct Service Ratio

Reasons for Collaborative Documentation

- Improved Quality of Care
  - Better Engagement with the Client
  - Better Outcome Achievement
- Higher Quality More Objective Documentation
- Improved Quality of life for the Provider

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Documentation Strategies That Support Collaboration

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

- Engagement
- Medical necessity and compliance
- Efficiency
Medical Necessity and the Golden Thread

Assessment Data

Diagnoses – Strengths – Life goals - Assessed Needs (Behavioral Health Problems/Challenges)

Service Plan Goals

Service Plan Objectives

Interventions and Services

Interactions Directed by Service Plan - Recorded in Progress Notes
Collaborative Documentation: Intake/Assessment

Know your assessment instrument!

- 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
Collaborative Documentation: Intake/Assessment

**Diagnoses:**
> Talk with client about what symptoms you have heard them identify and help them understand that this is what use to help us help them.

**Interpretative/Clinical Summary**
> Say “OK, let sum up what we’ve discussed today”. Document with the client.

**Identified Needs/Problems**
> Say, “So can you tell me the three things/symptoms you most want to be different. Then help them see what has complicated those symptoms and how/where/when these symptoms are impacting them the most. Ex: Client feels sad, has difficulty concentrating and does not have friends which is exacerbated by parents getting separated which is leading to isolation at home and school.
Treatment (Service) Plan
The Map to Client’s Treatment

Goals:

> Start with the Assess Need that you developed together. Client feels sad, has difficulty concentrating an does not have friends which is exacerbated by parents getting separated which is leading to isolation at home and school.

> Ask, “What do we want the outcome to be as we work on this issue”? Or ask “if we accomplished that what would you have or be able to do that you can’t now/” (i.e. life goals)? Discuss and enter a collaborative statement. **Ex: I will feel happy. I will have two friends and I will want to be with people instead of hiding in my room.**
Treatment (Service) Plan
The Map to Client’s Treatment - 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 an objective way

> Objectives are important to allow you and the client to tell if the work you are doing together is working.
Treatment (Service) Plan
The Map to Client’s Treatment Intervention

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.
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.
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 – “What did we do today that was helpful”.
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 (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.”
How Collaborative Documentation Became A Clinical Tool

The progress note transitioned from a note I had to get done by the end of the day to a note I wanted to complete with the client.

- As I changed my approach clients quickly transitioned and embraced the CD model.
- Clients responded to structure of the end of the session.
- Many clients expressed, “When you write what I say I feel heard and I like knowing what goes in my chart.”
- When a client knew what I was writing and contributed to the process they would engage more in the treatment.
Do as much as you can. . .

> Find a starting point
  
  - Pick at least one section of the progress note that you can complete with the client.
  
  - Start using that sections as a starting point for the following session
  
  - Remember that the documents are clinical tools to be utilized not forgotten

Katherine Hirsch, LCSW, MTM Clinical Consultant
Transition from Post Documentation to Collaborative Documentation Model

“Do As Much As You Can”

a. Complete the plan
b. Add mental status/functioning levels
c. Identify Goal and Objective addressed today
d. Add interventions provided
e. Add client’s response to the intervention section of the progress note
f. Complete progress note in session
Collaborative Documentation Requires a Shift in Thinking

> View collaborative documentation as an essential element of the therapeutic process.

> Project CD as a valuable interactive process so your clients perceive it this way.

> Be willing to adjust what you write so that clients understand.

> Setting routine is one of the best ways to get into habit for both you and the client.

> Implementation experience shows that collaborative documentation will become a habit within 6 weeks.
Collaborative Documentation for Progress Notes Taught Me…

> CD encouraged a review of the session which lead to clarification of client benefits of the session.

> Any misunderstandings during a session were identified and clarified before the client left.

> 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.
  ◦ Tasks that I agreed to complete were noted and reviewed at next session as well.
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.
Collaborative Documentation Setup

> **Script Elements** –

- This is *your* note/chart
- This is *your* care
- Writing the note now will help us ensure a higher quality note that better represents your progress
- *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
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”
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 Setup

How to Make it Happen:

- **Scripts** – Know how you are going to explain the process to your clients before your session.
- **Technology Needed** - What technology is needed/available?
- **Office Setup** – Do you need to move computers, screens, office furniture?
- **HIPAA Compliance** - Carrying information into the field offers specific risks.
- **Peer Support Pilot Program** – Identifying a group of staff to pilot CD and be leaders in transition.
- **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.
This is the exception not the rule!

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%
Response to Staff’s Initial Concerns Identified

“Collaborative documentation takes away from treatment”
Collaborative documentation can enhance the clinical treatment and the clients engagement in the treatment process

“There is no way to complete a progress note, treatment plan or assessment with a client.”
To consistently engage and encourage a clients investment in their progress, concurrent documentation is a technique that has shown improved commitment to treatment.

“There are no clinical benefits to completing the documents with clients, especially children and paranoid or psychotic clients.”
Children are not always easy to engage but when you write quotes from them and encourage them to write the note with they often express feeling heard. A psychotic client worries about what you write, until you show them there is nothing to hide.
Response to Staff’s Initial Concerns Identified

“Clients feel like all they do is paperwork”
Clients complain about paperwork if the staff reference the amount of paperwork required. Again, if you engage them in the process they do not typically indicate it as a problem.

“I need time to think about what I want to write before I complete a note.”
Using quotes from a client and working together to summarize the stressors, interventions and plan for utilizing techniques is more effective and accurate than thinking about what you want to write.

“You cannot complete documentation collaboratively during a crisis situation.”
Another word for crisis is opportunity. There are plenty of times that part of the resolution is to review triggers and a plan for managing the crisis which can be completed together.
QUESTIONS
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”?
> How do I use CD with children?
> 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?