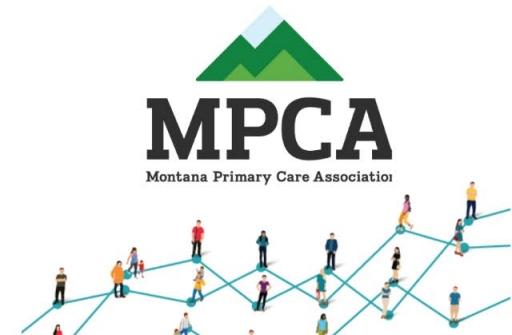
Collaborative Documentation

GINA PATE-TERRY LCSW, LAC

APRIL 27, 2023



Collaborative Documentation

Collaborative Documentation is different from concurrent documentation.

Collaborative Documentation is a process in which clinicians and patients collaborate in the documentation of the Assessment, Diagnosis, Planning, and ongoing clinical interactions (Progress Notes).

Collaborative Documentation is a **clinical tool** that provides patients with an opportunity to provide their input and perspective on services and progress and allows patients and clinicians to clarify their understanding of important issues.

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Collaborative Documentation…Simply put

- The patient is *present and engaged* in the process of documentation development.
- The Behavioral Health Provider prepares notes in a transparent, collaborative manner with the patient during the therapy session
- Allows patients and clinicians to clarify their understanding of important issues.

Is Therapeutic

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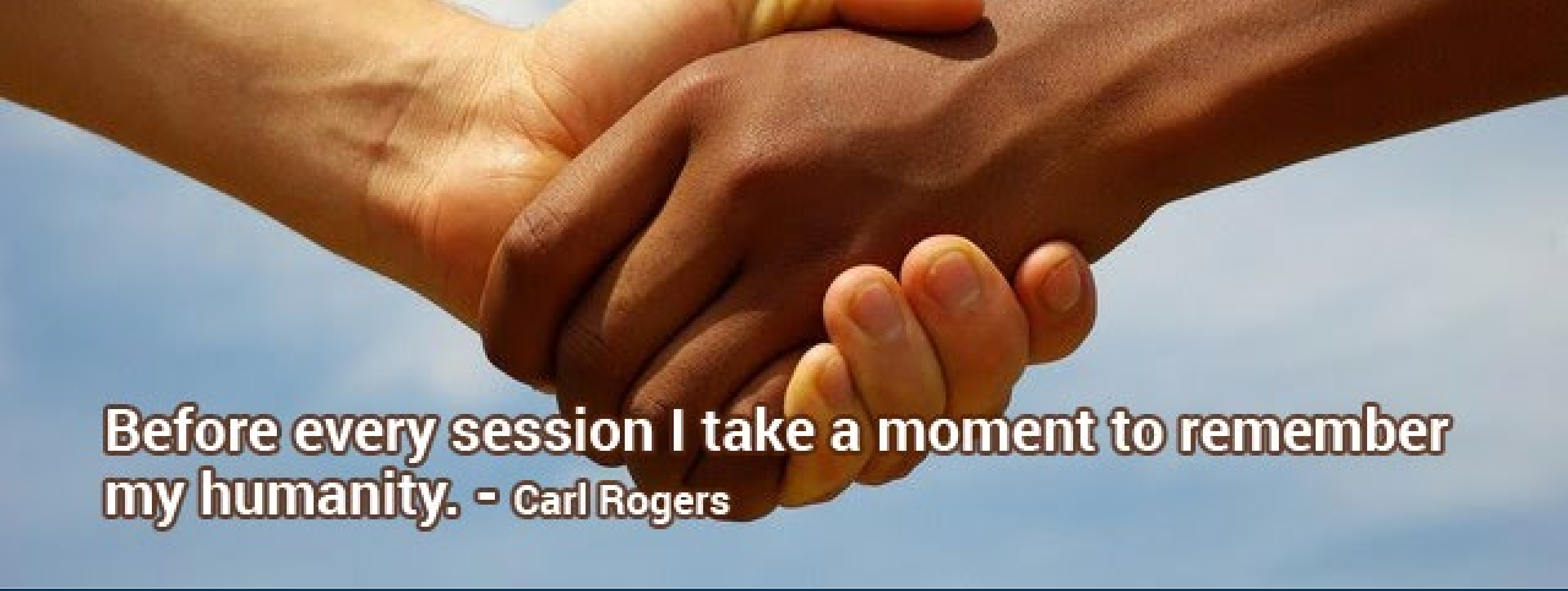
Integrates the Clinicians “Paper Life and Their “Clinical Life

Resulting in “Meaningful Documentation”



Collaborative Documentation is an Opportunity for Optimizing..

.. every interaction with our patients – The therapeutic relationship is enhanced

Cures Act

ONC's Cures Act Final Rule **supports seamless and secure access, exchange, and use of electronic health information.** The rule is **designed to give patients and their healthcare providers secure access to health information.** It also 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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Transparency – A New Way of Thinking

DID YOU KNOW?

8 in 10 individuals who have viewed their medical record online considered the information useful.[1]

27% of individuals were unaware or didn't believe they had a right to an electronic copy of their medical record.[1]

41% of Americans have never even seen their health information.[2]

HIPAA (Health Insurance Portability and Accountability Act of 1996) gives us the right to access our health information.

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Transparency -
A New Way

Behavioral Health Providers are used to documenting "their analysis of session content" without any expectation that the patient will ever view it. This is no longer true.

It is no longer uncommon for patients to register for an online portal

Patients who know what's going on "behind the scenes" can communicate better with those who provide them services

Collaborative Documentation is a way for us to process with our patient and be more transparent.

Enables clinician to write progress notes rather than process notes

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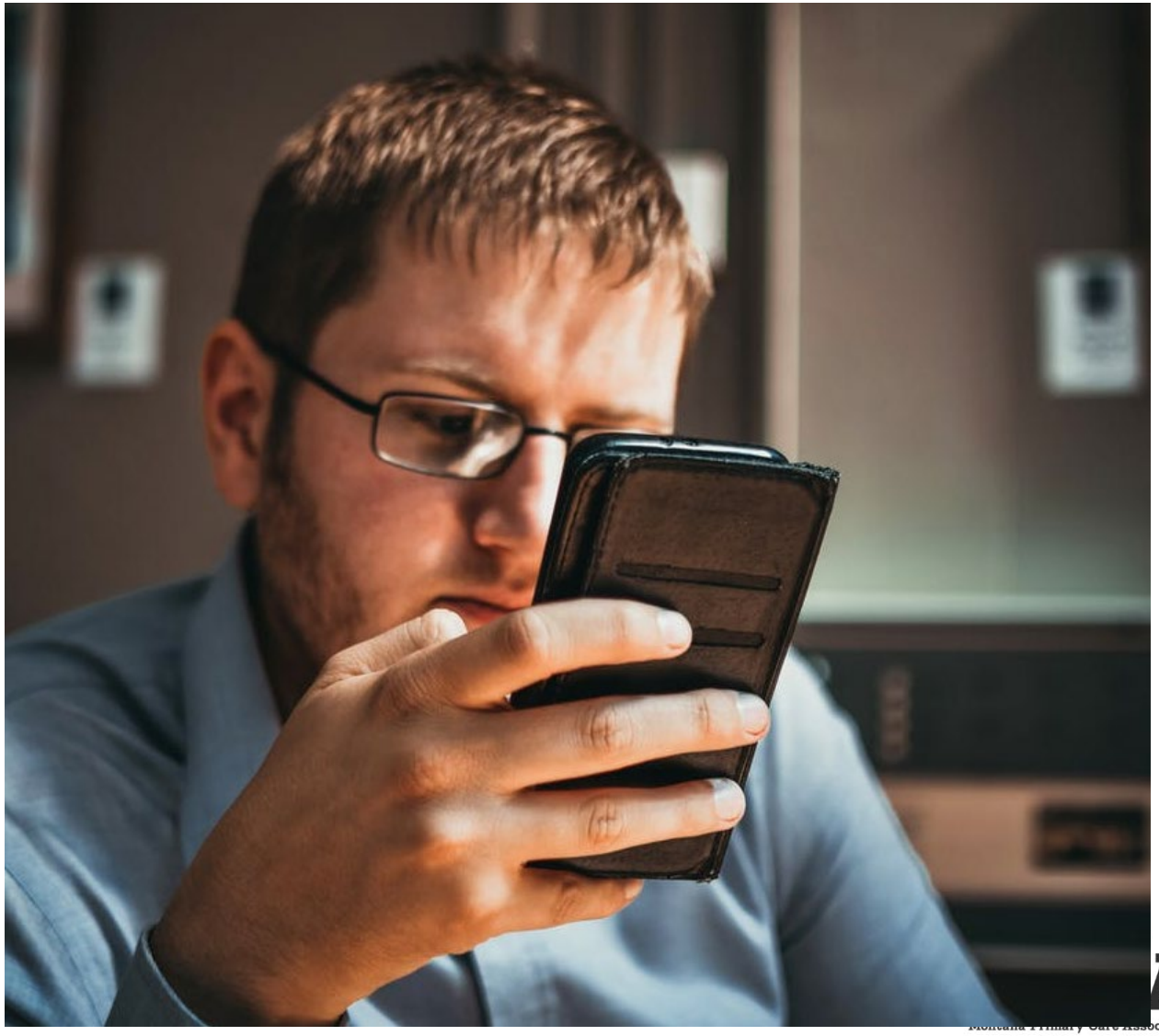
Assume Your…

- Patients will read the documentation of their visits – Psycho-babble (patient is experiencing visual hallucinations as opposed to patient said she has seen purple people coming out of the house across the street)
- Notes will be subpoenaed – no surprises
- Activities will need to be justified to a payer source – on time



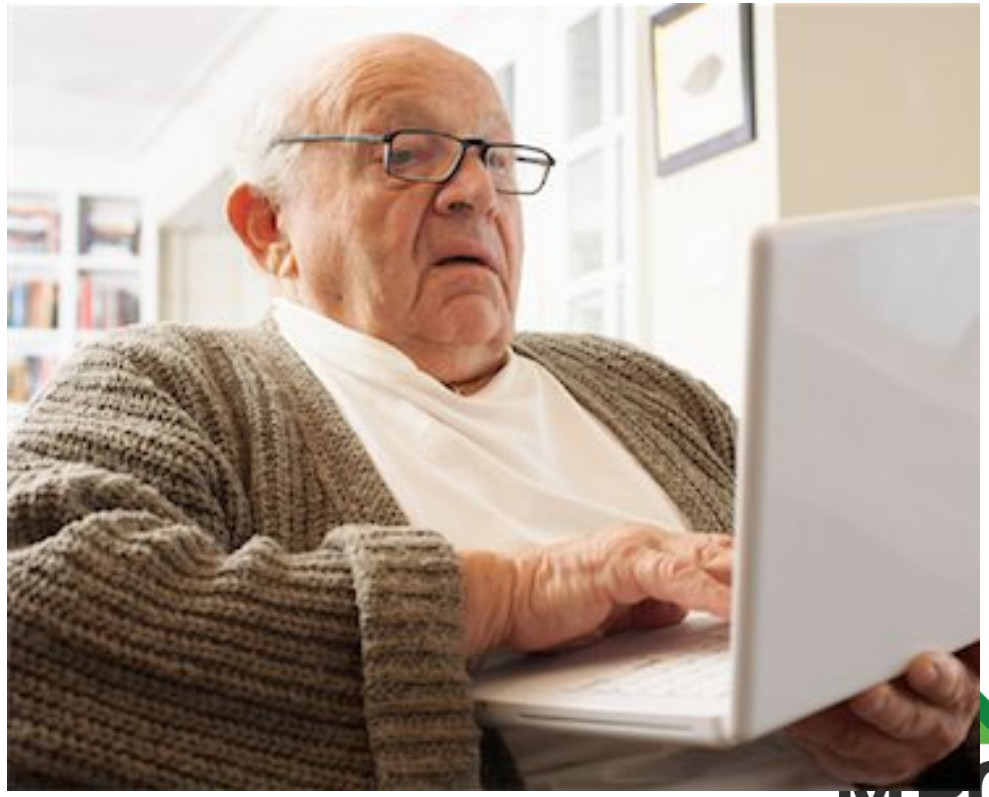
Research Results on Transparency

Improve trust through increased transparency

Created a platform for providing feedback to patients that prompted insights into behaviors and cognitions more quickly than before.

Therapist comfort level and skills appeared to influence 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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Patient's Report on Transparency

A study published in 2012 in the Annals of Internal Medicine found that patients felt more in control of their health care, understood their conditions better, and took medication more appropriately when allowed access to their providers' notes.

Patients were not offended or troubled by what was written about them.

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Against the Wall

"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

Documenting Collaboratively Improves the Quality of Your Work-life

Documentation has become “The ENEMY”

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

They schedule documentation time to catch up, which reduces patient’s access to treatment…creates wait lists

Clinicians report that documentation competes with their time spent with clients and is divorced from the clinical work

Working collaboratively is “Meaningful Documentation”

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Saves Significant Time and Creates Capacity

Documentation becomes timely, and consequently provides "value for risk-management."

Increases clinician capacity to see more patients, and improves compliance with agency productivity and performance standards

- **Time Savings and Access**
  - **Project outcome data demonstrates that 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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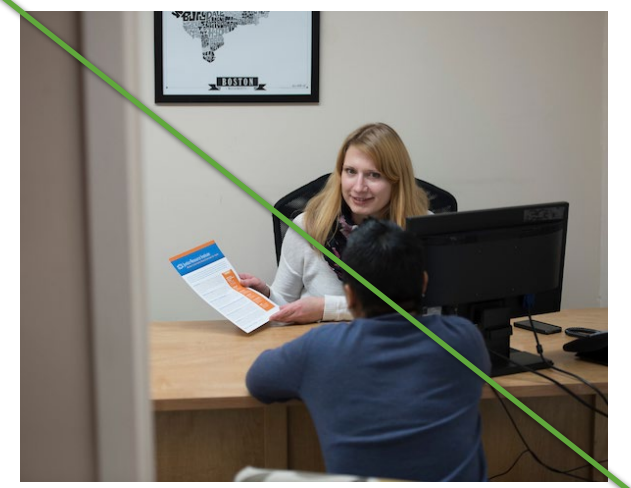
Start and End the Encounter at the Computer

From the very beginning – the medical record is a part of the session

Lap Top

Two chairs

Three chairs



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Elements of Your Script

- **“This is your medical record”**
- **“This is your care that we want to document”**
- **“This note documents your progress”**
- **“We will only take notes during the last 5 minutes of your session”**
- **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**
  - **Existing patient - Start small – take one piece of the note (?)**
  - **New patient – Go for it!**

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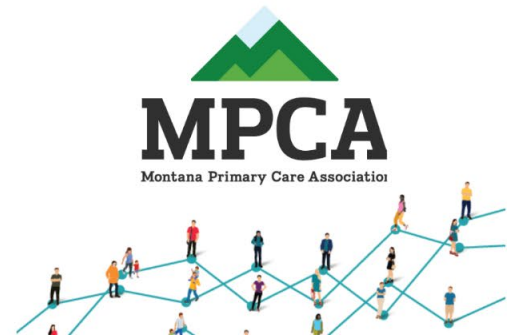
Introduction - Script

`Katherine Hirsch, LCSW MTM

“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 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.”



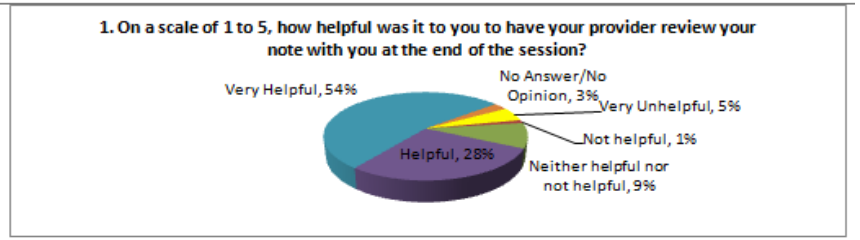
SAMHSA STUDY

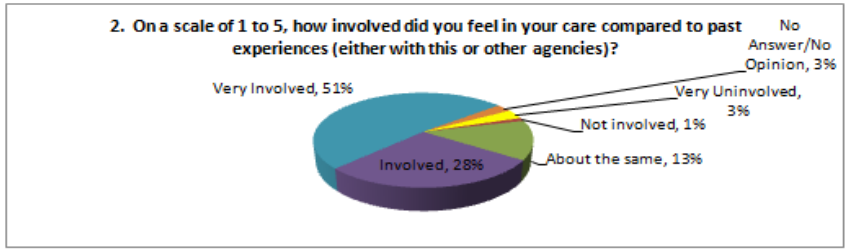
1. On a scale of 1 to 5, how helpful was it to you to have your provider review your note with you at the end of the session?		Percentages Total	Total %
1	Very Unhelpful	397	5%
2	Not helpful	93	1%
3	Neither helpful nor not helpful	726	9%
4	Helpful	2215	28%
5	Very Helpful	4218	54%
NA	No Answer/No Opinion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

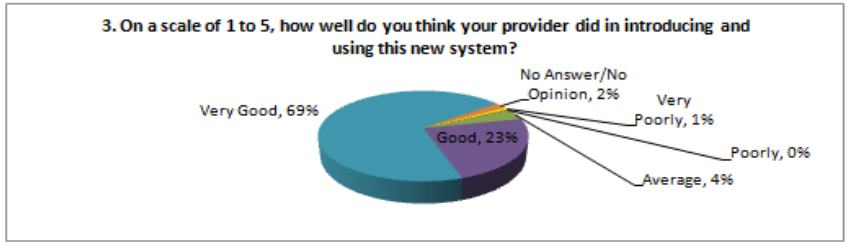
2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)?		Total	Total %
1	Very Uninvolved	222	3%
2	Not involved	76	1%
3	About the same	930	13%
4	Involved	1943	28%
5	Very Involved	3552	51%
NA	No Answer/No Opinion	184	3%
	Total/Approval %:	6907	96%

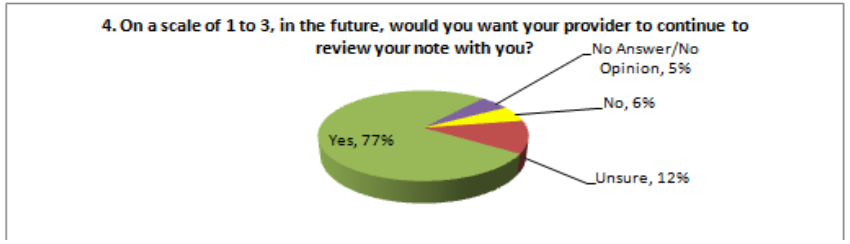
3. On a scale of 1 to 5, how well do you think your provider did in introducing and using this new system?		Total	Total %
1	Very Poorly	45	1%
2	Poorly	20	0%
3	Average	271	4%
4	Good	1593	23%
5	Very Good	4730	69%
NA	No Answer/No Opinion	157	2%
	Total/Approval %:	6816	99%

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%









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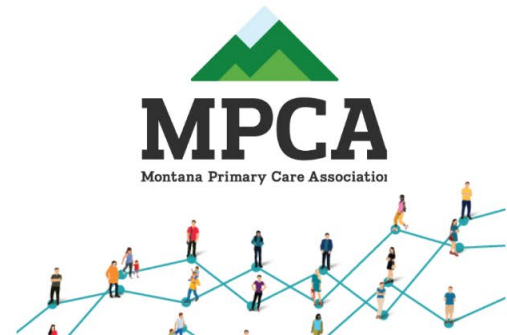
The 7% Percent Factor

There are situations where collaborative documentation is not appropriate

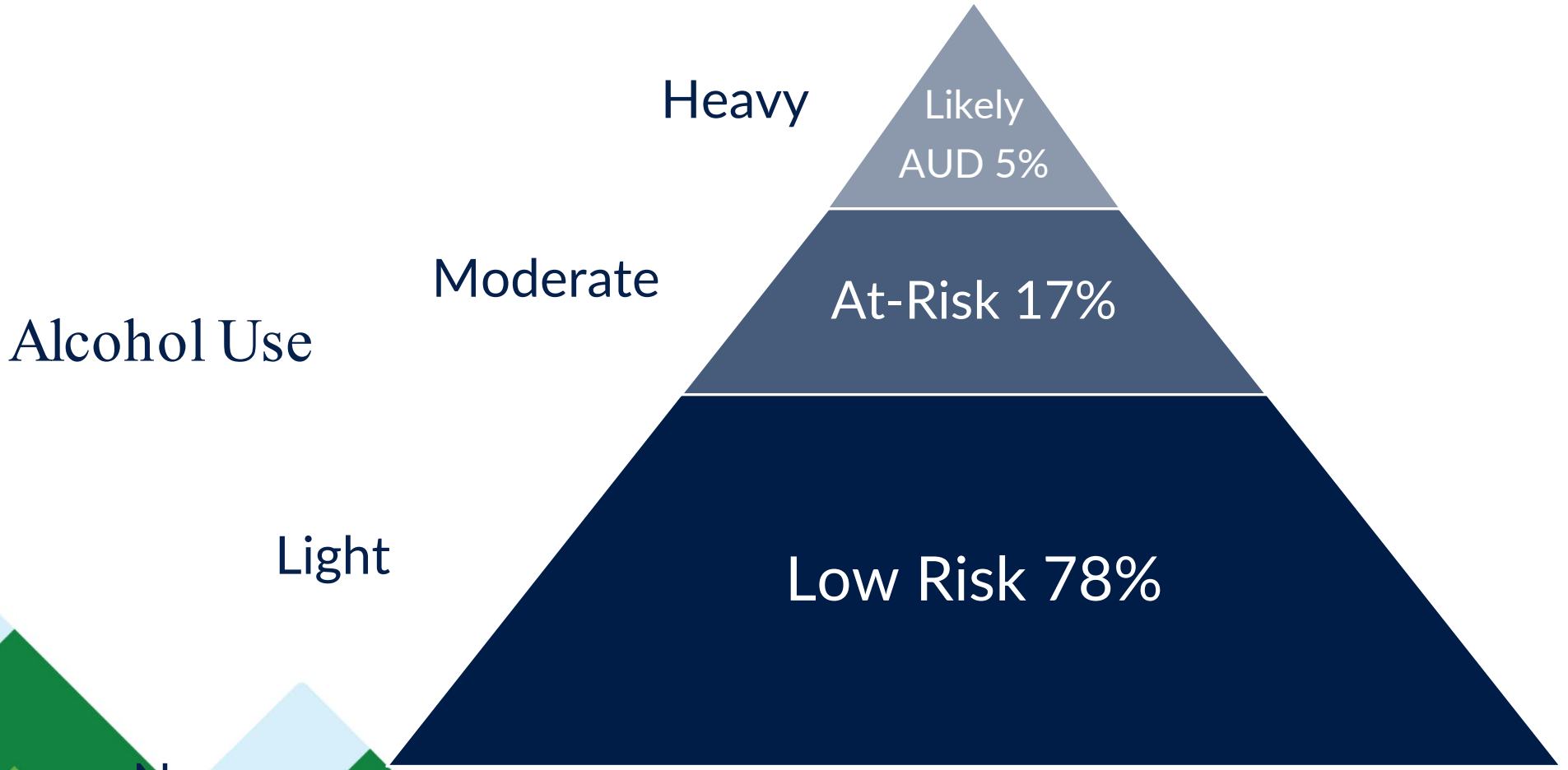
93% of the time collaborative documentation is appropriate, positive and helpful.

Failures to implement are often due to a focus on the 7%



Does it work with patients who have a SUD?

You Already Are Talking to Them



Normalizing Talking About Substance Use in Primary Care

Rankings of Preventive Services
National Commission on Prevention Priorities

25 USPSTF-recommended services ranked by:

- **Clinically preventable burden (CPB)** -
  How much disease, injury, and death would be prevented if services were delivered to all targeted individuals?
- **Cost-effectiveness (CE)** - return on investment - How many dollars would be saved for each dollar spent?

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Ranking of Preventive Services

#	Service	CPB	CE
1	Aspirin - Men - 40+, Women - 50+	5	5
2	Childhood immunizations	5	5
3	**Smoking cessation**	**5**	**5**
4	**Alcohol screening & intervention**	**4**	**5**
5	Colorectal cancer screening	4	4
6	Hypertension screening & treatment	5	3
7	Influenza immunization	4	4
8	Vision screening - 65+	3	5

Maciosek, Am J Prev Med 2006; Solberg, Am J Prev Med 2008; http://www.prevent.org/content/view/43/71

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Health Care Providers:

View patients with SUDs differently

- Have lower expectations for health outcomes
  - Perceived Control
  - Perceived Fault

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How Do Patients React to Alcohol Screening?

The University of Connecticut School of Medicine's "*Cutting Back Study*"

Some medical personnel believe that when patients are asked about their drinking, many are uncomfortable and resistant. One reason personnel typically give for not asking about alcohol use is that "drinking behavior is private." This view is not, however, supported by research.

Screened primary care patients in five states for smoking, diet/exercise, and alcohol use.

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Patients were asked two questions

How comfortable do you feel answering these questions?

How important do you think it is that your health care provider knows about these health behaviors?

They were asked to express their views on a five-point scale from “very comfortable” and “very important” to “very uncomfortable” and “very unimportant”

FEWER THAN 9% OF PATIENTS INDICATED ANY DISCOMFORT OR ANY THOUGHT THAT SUCH INFORMATION WAS UNIMPORTANT TO THEIR HEALTHCARE PROVIDERS.

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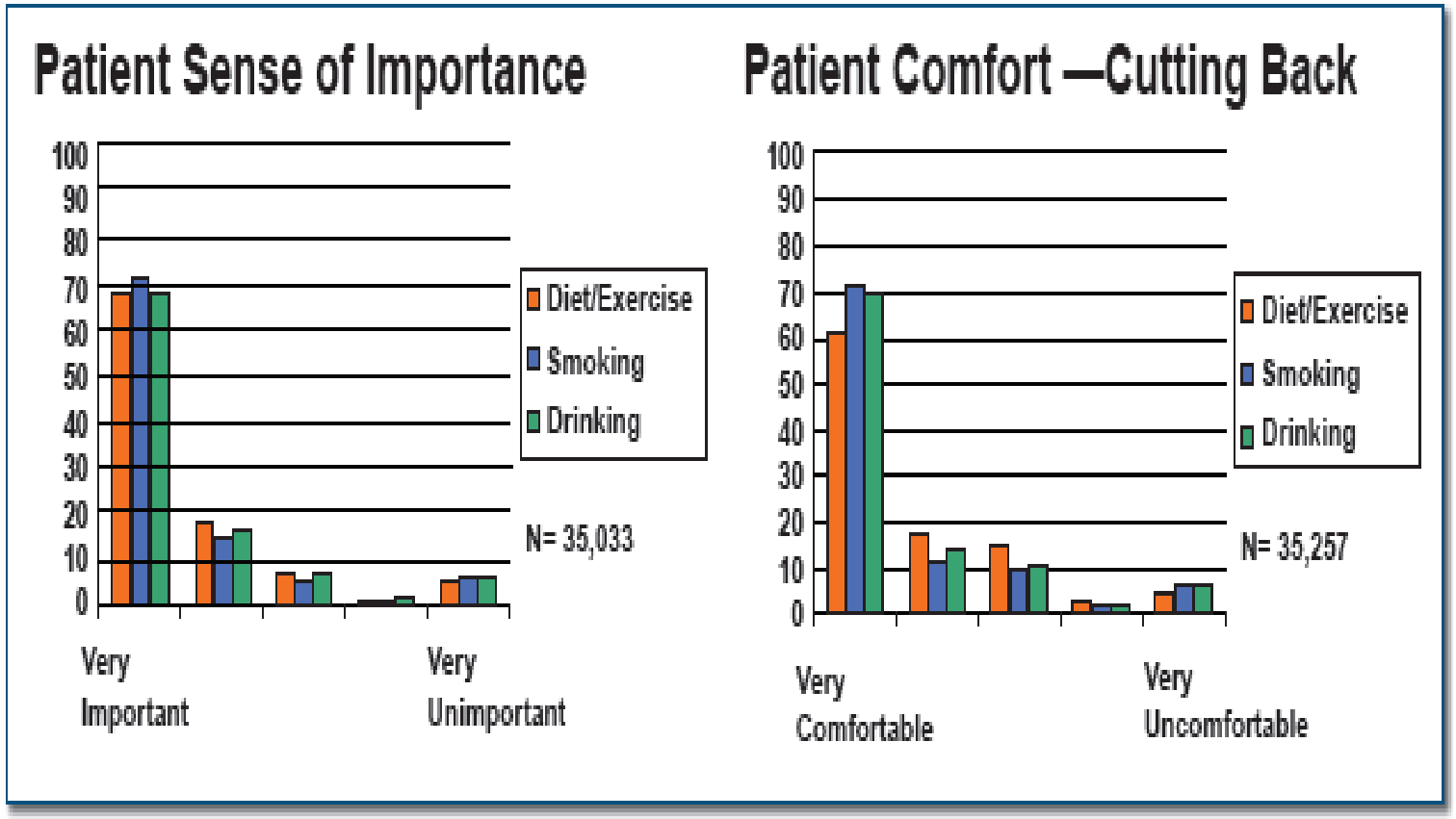
The University of Connecticut School of Medicine's *"Cutting Back Study"*



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With the Spirit of Collaborative Documentation

Seeing a person's defensiveness or resistance as a natural and/or therapeutic process, not pathological

Using The Golden Thread of documentation to present *relevant clinical information with the patient* throughout your documentation

Assessment

Goal: Establish qualification for services

- Symptoms
- Functional impairments/ consequences
- ICD-10 / DSM-5 criteria – DAST – AUDIT - 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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AUDIT

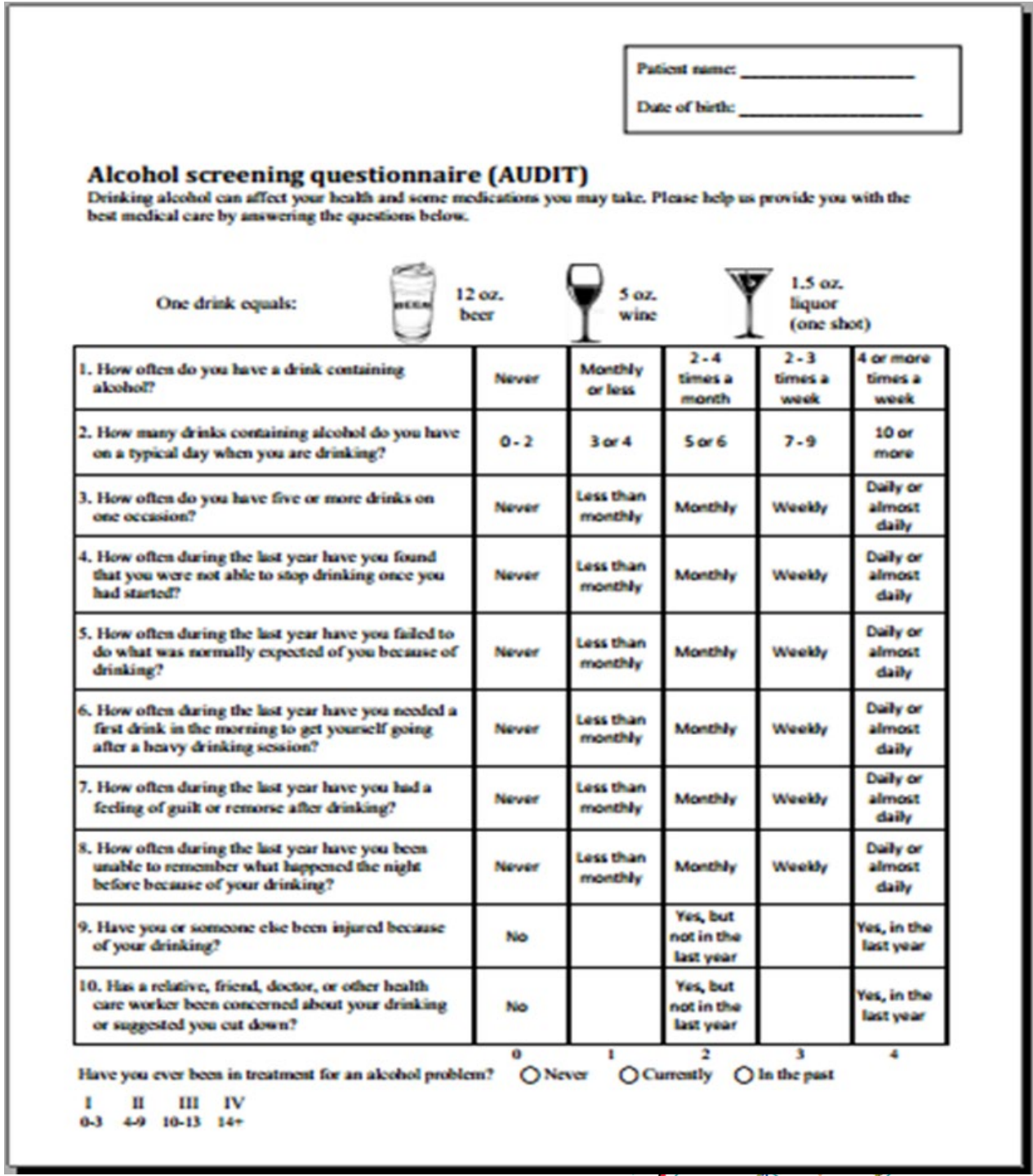
Alcohol screening questionnaire

0 to 7 points: Low risk

8 to 15 points: Medium risk

16 to 19 points: High risk

20 to 40 points: Addiction likely



Patient name: _____

Date of birth: _____

Alcohol screening questionnaire (AUDIT)

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals: 12 oz. beer; 5 oz. wine; 1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ○ Never ○ Currently ○ In the past

I	II	III	IV
0-3	4-9	10-13	14+

DAST-10

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed, hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions **do not include alcohol or tobacco**.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

These questions refer to the past 12 months	No	Yes
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes")	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse (or parent) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.?	0	1

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Diagnosis

Symptoms must support the diagnosis

Does our patient have a substance use disorder?

The DSM-5 defines a substance use disorder as the presence of at least 2 of 11 criteria.

Criterion	*Category*
1. Taking more or for longer than intended	Impaired Control
2. Unsuccessful efforts to stop or cut down use	
3. Spending a great deal of time obtaining, using, or recovering from use	
4. Craving for substance	
5. Failure to fulfill major obligations due to use	Social Impairment
6. Continued use despite relationship problems caused or exacerbated by use	
7. Important activities given up or reduced because of substance use	
8. Recurrent use in hazardous situations	Risky Use
9. Continued use despite physical or psychological problems	
10. Tolerance to effects of the substance*	Physiologic Adaptation
11. Withdrawal symptoms when not using or using less.*	

* Persons who are prescribed medications are not necessarily to be considered to have a substance use disorder

Mild = 2-3 criteria, Moderate = 4-5 criteria, Severe = 6 or more criteria

Biopsychosocial Assessment – Collaborative and Concurrent

https://medicaidprovider.mt.gov/

Treatment Plan

- Goal: Establish a plan for how assessed needs will be met during treatment and how it will be measured
- Keep it Simple
- Ask Permission
- Something they want to do (may have worked before)
- Consider Harm Reduction
- Use your screening tools (measurable)

Progress Notes

The Golden Thread: Progress Notes

The progress notes must flow from the treatment plan by specifically reflecting the service provided, the consumer's participation in their treatment, progress towards the identified steps/objectives and overarching goals, and the consumer's response to treatment.

Medicaid is interested in knowing that they are funding a beneficial and medically necessary service and treatment.

The Progress Note

“The progress note transitioned from a note I had to get done by the end of the day to a note that I looked forward to completing with the patient.”

~Katherine Hirsch, LCSW

www.thenationalcouncil.org

Progress Notes:

- Must be tied to treatment plans in a meaningful way
- Documentation of the skilled interventions provided, and how patient responded
- Documentation of clinical progress clinical improvements (or at the very least, prevent symptoms from worsening)

Readable – not too “clinical” or too much jargon

Useful to: – Patient – Clinician – Anyone else involved in patient’s care –

- Address all assessed symptoms, deficits, and functional impairments resulting from the diagnosis–

Demonstrates clinical necessity

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Last Words

View Collaborative Documentation as an essential element of the therapeutic process

Let go of your ego and write what your patient will understand

Any misunderstanding that might happen during the session can be identified and resolved before the patient leaves

Quick Review Collaborative Documentation

Goes with MI model in that it is collaborative and where we incorporate the patients perspective on their progress and service and it gives us ant them a better understanding of the important issues

Clinician and patient must be present and engaged in the process of the documentation

Saves time

Helps with increasing performance demands

Improves patient engagement and involvement

Supports person-centered services

Improves quality of work life for clinicians

Goal is to integrate clinicians “paper life and “clinical life

It is time with the patient and number one complaint is that paperwork takes us away from them

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Questions?