Collaborative documentation is a team effort between a client and his/her service provider to create a record that documents the session content and process in real time with the client present. Basically the process involves incorporating an active discussion (throughout and) at the end of the service encounter and documenting the information into the EMR. The client must be present and engaged in the process of documentation.
**BENEFITS OF Collaborative Documentation (CD)…**

This is a shift from the traditional (but ineffective and inefficient documentation model in which the provider writes a “private” note in the chart some time after the session has ended. With CD, “when the client’s hand touches the door to leave,” the clinical work and documentation are complete (unless a minute or two is needed to wrap up the documentation/billing).

- CD allows the service provider to review/confirm with the client in a proactive manner
- The goals and objectives addressed during the session
- The therapeutic interventions provided by the treating clinician/prescriber
- Their feedback regarding progress made and an indication of the perceived benefit of the service
- Agreements on plans for clinician to complete and client to do prior to next session
- Agreed time frame for next appointment

In addition, CD is an appropriate extension of the therapeutic interaction that serves to focus the client on what just occurred in the session as well as their next steps in the process of their treatment/recovery.

**STEPS PRIOR TO BEGINNING Collaborative Documentation**

- Review the wait time from first call to the appointment after completion of the treatment plan to verify need for change.
- Streamline documentation: reduce the documentation requirement, review forms for repetitive requests for same information, elements no longer required, and roadblocks for clients and staff to be able to do this process.
- “Nothing is less productive than to make more efficient what should not be done at all” Peter Drucker
- The most effective standardized documentation outcomes are based on the ability to address duplicity of paperwork as an organization-wide problem that can have enormous effects on maximizing service capacity, HIPAA compliance, and Corporate Compliance. Often identified tasks for a Forms Committee to work on combining, streamlining, standards, wording, and goals can make this process more effective if they adopt two principles:
  - 1) the organization will not ask the consumer for the same information more than once; and
  - 2) all standardized documentation will be developed to serve the MH/DD/MR/SA needs of all consumers. On this team, everyone brings samples of forms to work together as a whole to prevent overlap or duplication of information and to review for local, state, accrediting body, and any other standards for documentation.
STEPS PRIOR TO BEGINNING Collaborative Documentation

- Ongoing concerns are that if an external audit occurred, documentation in the chart would not meet compliance standards or would not be completed on the audit date. It is clear that auditors are not looking at how many words are written in the chart, but rather which words are written.
  - Progress notes that recorded the problem, process of treatment and methodology that the clinician is utilizing will pass quantitative audits and must include information on goals and objectives from the treatment plan to be compliant with a qualitative audit. Therefore, using a shorter narrative is far more effective from both audit, billing and time perspective.
- Clients are asked the same questions by multiple staff, when they change or add programs, prior to intake, at intake, annually, etc.
  - Create a system in your EHR that allows for flow of information or one location that all can access.
- Among staff paperwork is one of the top frustrations to delivering care.
  - Work together to standardize the documentation and limit need for repeated questions within the documents to be completed.
  - Check on the source for need for this and make sure it is something that is needed and not just a tradition with the agency. With out this staff feel that they can never finish their work, compliance falls behind, and it becomes less useful.
  - Helpful items for us were to work with EHR and have some items from forms flow to the next form.
    - For example, the treatment plan goals, interventions, processes now connect to the progress notes as well as the crisis plan and diagnosis. We are allowed to chose items, add new ones, and adopt them as needed. Also the copy feature can be helpful with making some changes and still working on the same goals.

BENEFITS OF COLLABORATIVE DOCUMENTATION

To the client:

- Able to be more involved in the process
- Empowered to know and determine the course of assessment, interventions and progress of therapy
- Real-time feedback
- Increased knowledge
- More available appointments slots
BENEFITS OF COLLABORATIVE DOCUMENTATION

To the staff:
- Enhances the therapeutic value of the session
- Increases content accuracy
- Can save hours per week
- Eliminates the staff “treadmill”
- Compliance reduces pushback from supervisors, billing staff, management
- Can reduce anxiety and stress
- Can promote higher job satisfaction, better staff morale, and improved quality of life

To the Mental Health Center:
- Sets a standard for clinical formulation among all staff to assure documentation is:
  - Accurate and complete
  - Consistent and compliant with applicable state, federal and accreditation standards
- Increased compliance lowers likelihood of audit paybacks
- Increased availability will improve/increase access for clients needing our services
- Increased staff morale and enhanced quality of life can reduce staff burn-out and turnover
FOR NOW, CONSIDER:
The Golden Thread of Medical Necessity:

Assessment Data
  ↓
Diagnoses – Strengths – Personal Goals
Assessed Needs
  ↓
Treatment Plan Goals and Objectives
  ↓
Interventions and Services
  ↓
Interactions Directed by Treatment Plan and recorded in EMR

TRANSITIONING FROM POST-DOCUMENTATION TO COLLABORATIVE DOCUMENTATION

1. INTRODUCE THE PROCESS TO STAFF
   Working towards developing a documentation model that supports:
   ❖ Compliance – medical necessity, client participation, client benefit
   ❖ Outcome-oriented, person-centered services
   ❖ Efficiency
TRANSITIONING FROM POST-DOCUMENTATION TO COLLABORATIVE DOCUMENTATION

Role of the Supervisor:

- Help clinicians consider how they might do this/what they might say
- Support the change and encourage to see the benefits
- Start with someone who wants to do it
  - Helps others see it’s possible
  - Having a Champion who can train others can make the transition easier for others and highlight the benefits

TRANSITIONING FROM POST-DOCUMENTATION TO COLLABORATIVE DOCUMENTATION

- It IS possible to do bad collaborative documentation and that is not our goal!!!
- Process and content must enhance the therapeutic stance (not undermine it)
  - No constant typing without eye contact or attention to non-verbal cues
  - Use client’s words
  - Avoid pejorative terms
TRANSITIONING FROM POST-DOCUMENTATION TO COLLABORATIVE DOCUMENTATION

2. INTRODUCE THE PROCESS TO YOUR CLIENT (in a positive, inviting way)

*Collaborative documentation sample scripts:*

“**Usually** after we meet I write a note in your chart summarizing our session. Today we will be starting something new that will help us work even better together. We will do what we usually do, except that during the last 5-10 minutes we will write some of the chart note together. This is called collaborative documentation. The note we write will cover which of your goals we worked on, the things I did in session to help you reach your goals, a review of your progress, things to be worked on between sessions, and how you felt about the session. This process will help us stay focused and in agreement about what we did today. Do you have any questions? “

“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. Do you have any questions?”

TRANSITIONING FROM POST-DOCUMENTATION TO COLLABORATIVE DOCUMENTATION

3. Jump in with the “Do As Much as You Can” Approach

- For the first 10 or so clients, try to do nothing different until the end. Conduct your session as usual.
- Then you can start with client response to the interventions/session.
  - In the last 5-10 minutes of the session, ask the client, “was our time today helpful to you?” or “has this been helpful?” and then document their feedback. (As you are typing and they are looking at the screen, check with them to make sure you got it right) . . . “So, Jane, you thought reviewing the skills you’ve learned to manage your anxiety and practicing pace breathing was a big plus today, have I got that right?”
- As you get more comfortable with the process, you may also begin to concurrently document:
  Goals and objectives addressed during the session, then
  Therapeutic interventions provided and then
  Add mental status, functioning levels, plan if applicable.
TRANSITIONING FROM POST-DOCUMENTATION TO COLLABORATIVE DOCUMENTATION

ROLE OF THE PILOTEER

- The key to success
- View CD as an essential element of the therapeutic process
- Project it as a valuable interactive process
- Make it routine
- Be a role model and a support for your peers
- Sell the benefits

PASSING ON WHAT WE’VE LEARNED

- Office space
- Dealing with antiquated beliefs of staff
- Incorporating new tricks
- Need to modify templates
- Tyranny of the Urgent
3) “CLIENT RESPONSE TO COLLABORATIVE DOCUMENTATION PILOT PROGRAM” EVALUATION.

- This is completed by each client only once per provider, at the end of the first session in which CD was used. (A client may complete one with a therapist and one with a prescriber).

- It is your job to ensure that the client understands the survey questions. You might read it aloud and wait for the client to respond to each item or let them complete it.

- Stress to the client that their feedback is important, confidential and private. They can complete the form with you and turn it in to the receptionist or a drop box on their way out.

---

**Result of clinicians versus clients for process:**

**FLMHC Staff Survey**

<table>
<thead>
<tr>
<th>1. How long have you been doing concurrent documentation?</th>
<th>Percentages</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Two or more months</td>
<td>3</td>
<td>33%</td>
</tr>
<tr>
<td>2</td>
<td>One to two months</td>
<td>2</td>
<td>22%</td>
</tr>
<tr>
<td>3</td>
<td>One month or less</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>4</td>
<td>Have not started concurrent documentation</td>
<td>4</td>
<td>44%</td>
</tr>
</tbody>
</table>

Total/Approval %: 9

How long have you been doing concurrent documentation?

- 2 or more months
- 1 to 2 months
- 1 month or less
- Haven't started yet

Pie chart shows:
- 45% for 2 or more months
- 33% for 1 to 2 months
- 22% for 1 month or less
- 0% for Haven't started yet
### FLMHC Staff Survey

#### 2. On a scale of 1 to 5, how easy was it to learn to do concurrent documentation?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Uneasy</td>
<td>2</td>
<td>40%</td>
</tr>
<tr>
<td>Not Easy</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>Neither easy nor not easy</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>Easy</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>Very Easy</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>No Answer/No Opinion</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Total/Approval %:</strong></td>
<td><strong>5</strong></td>
<td><strong>60%</strong></td>
</tr>
</tbody>
</table>

On a scale of 1 to 5, how easy was it to learn to do concurrent documentation?

- Very Easy: 20%
- Not Easy: 40%
- Neither Easy nor Not Easy: 20%
- Easy: 20%
- Very Easy: 20%
- No Answer/No Opinion: 20%

#### 3. On a scale of 1 to 5, how helpful is concurrent documentation to the treatment process?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Unhelpful</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>Not helpful</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>Neither helpful nor not helpful</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>Helpful</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>Very Helpful</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>No Answer/No Opinion</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total/Approval %:</strong></td>
<td><strong>5</strong></td>
<td><strong>60%</strong></td>
</tr>
</tbody>
</table>

On a scale of 1 to 5, how helpful is concurrent documentation to the treatment process?

- Very Helpful: 17%
- Not Helpful: 16%
- Neither Helpful nor Not Helpful: 17%
- Helpful: 17%
- Very Helpful: 16%
### FLMHC Staff Survey

#### 4. On a scale of 1 to 5, how involved are your clients in the treatment process as a result of using concurrent documentation?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very Uninvolved</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>2</td>
<td>Not involved</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>3</td>
<td>About the same</td>
<td>2</td>
<td>40%</td>
</tr>
<tr>
<td>4</td>
<td>Involved</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>5</td>
<td>Very Involved</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>NA</td>
<td>No Answer/No Opinion</td>
<td>1</td>
<td>20%</td>
</tr>
</tbody>
</table>

Total/Approval %: 5 100%

On a scale of 1 to 5, how involved are clients in the treatment process as a result of using concurrent documentation?

#### 5. On a scale of 1 to 5, how helpful has concurrent documentation been on your paperwork proficiency?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very Unhelpful</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>2</td>
<td>Not helpful</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>3</td>
<td>Neither helpful nor not helpful</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>4</td>
<td>Helpful</td>
<td>2</td>
<td>40%</td>
</tr>
<tr>
<td>5</td>
<td>Very Helpful</td>
<td>2</td>
<td>40%</td>
</tr>
<tr>
<td>NA</td>
<td>No Answer/No Opinion</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Total/Approval %: 5 60%

On a scale of 1 to 5, how helpful has concurrent documentation been on your paperwork proficiency?
6. On a scale of 1 to 3, has concurrent documentation had any impact on your workplace satisfaction?

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No Impact</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Some Impact</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Much Impact</td>
<td>2</td>
</tr>
<tr>
<td>NA</td>
<td>No Answer/No Opinion</td>
<td></td>
</tr>
</tbody>
</table>

**Total/Approval %:** 5 | 0.8

On a scale of 1 to 5, how helpful has concurrent documentation been on your paperwork proficiency?

- No Impact: 0%
- Some Impact: 20%
- Much Impact: 40%
- NA No Answer/ No Opinion: 40%

Comments from Staff Members regarding Collaborative/Concurrent documentation:

- It is a work in progress
- Few leftovers each day
- Do not plan to do concurrent
- The volume of paperwork is more the problem that doing it concurrently
- Do not like not looking at the client
## FLMHC Client Survey Response

### 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?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Total</th>
<th>Total %</th>
<th>Nat. Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Unhelpful</td>
<td>2</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Not helpful</td>
<td>1</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Neither helpful nor not helpful</td>
<td>2</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Helpful</td>
<td>4</td>
<td>25%</td>
<td>33%</td>
</tr>
<tr>
<td>Very Helpful</td>
<td>6</td>
<td>38%</td>
<td>48%</td>
</tr>
<tr>
<td>No Answer/ No Opinion</td>
<td>1</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total/Approval %:</strong></td>
<td><strong>16</strong></td>
<td><strong>81%</strong></td>
<td><strong>93%</strong></td>
</tr>
</tbody>
</table>

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?

- Very Unhelpful
- Not Helpful
- Neither helpful nor not helpful
- Helpful
- Very Helpful
- NA No Answer/ No Opinion

### 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)?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Total</th>
<th>Total %</th>
<th>Nat. Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Uninvolved</td>
<td>1</td>
<td>7%</td>
<td>3%</td>
</tr>
<tr>
<td>Not involved</td>
<td>0</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>About the same</td>
<td>3</td>
<td>20%</td>
<td>9%</td>
</tr>
<tr>
<td>Involved</td>
<td>1</td>
<td>7%</td>
<td>34%</td>
</tr>
<tr>
<td>Very Involved</td>
<td>8</td>
<td>53%</td>
<td>50%</td>
</tr>
<tr>
<td>No Answer/ No Opinion</td>
<td>2</td>
<td>13%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Total/Approval %:</strong></td>
<td><strong>15</strong></td>
<td><strong>93%</strong></td>
<td><strong>96%</strong></td>
</tr>
</tbody>
</table>

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)?

- Very Uninvolved
- Not Involved
- About the same
- Involved
- Very Involved
- No answer/ No Opinion

---

**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)?**
### FLMHC Client Survey Response

#### 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?

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Total %</th>
<th>Nat. Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>7%</td>
<td>23%</td>
</tr>
<tr>
<td>5</td>
<td>12</td>
<td>80%</td>
<td>68%</td>
</tr>
<tr>
<td>NA</td>
<td>1</td>
<td>7%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Total/Approval %:** 15 out of 15 (100%)

On a scale of 1 to 5, how well do you think your therapist or case manager did introducing and using this new system?

![Pie chart showing distribution of responses]

#### 4. On a scale of 1 to 3, in the future, would you want your provider to continue to review your note with you?

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Total %</th>
<th>Nat. Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>11%</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>87%</td>
<td>79%</td>
</tr>
<tr>
<td>NA</td>
<td>1</td>
<td>7%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Total/Approval %:** 15 out of 15 (100%)

On a scale of 1 to 3, in the future, would you want your provider to continue to review your note with you?

![Pie chart showing distribution of responses]
FLMHC Client Survey Comments:

Comments from Clients regarding Collaborative/Concurrent documentation:

- I feel it is beneficial to us both.
- Great information session in all areas.
- It is my opinion, digital writing is not as fast and reliable as records via pen and paper.

TRANSITIONING FROM POST-DOCUMENTATION TO COLLABORATIVE DOCUMENTATION

And where are we at today in this process that we have been working to achieve?

4) As you incorporate CD into your regular practice, please stay mindful of:
   - Initial challenges
   - Client reactions
   - Barriers/obstacles
   - Strategies you've identified to overcome barriers and obstacles
   - Are you stuck? Struggling?
   - Tips for others
   - Overall experience