CONCURRENT DOCUMENTATION CASE STUDY NOTES - 4/6/06
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Through many years as a mental health center medical director, I have been in search of the holy grail of documentation: quick and easy to perform, rapidly accessible, containing needed data and helping to guide clinical activity and decision-making in a rational direction, with linkages to needed medical information, like drug interactions.

It goes without saying this could not happen in the world of the paper chart, at least not in our setting, with diverse services and clinicians contributing to the medical record.

Our first attempts at electronic clinical documentation back in the 90's were text-based, essentially a typescript printed up, signed and placed in the paper medical record. This was abandoned after a trial.

I had thought drug information and interaction programs would be useful, but found similarly that they were too slow – just a few seconds of delay make them unusable in a busy practice.

Moving to electronic record-keeping was inevitable, however, and became more practical as computers speeded up.

I found myself increasing the use of the computer in session, for example, to access information about unusual treatments or other treatment centers on Internet, and increasingly with clients present. I would turn the screen on my desk to show clients the information we had retrieved, or maybe to teach them how one went about getting worthwhile medical information on the Internet. When we instituted a drug information program on the network, I started showing clients what I was doing, and they were interested in the process. They would often ask me to look up something else for them.

I wanted to have a program that would populate a note with client information: dates of services, medication history, meds prescribed by others, medical history, consents, AIMS tests, lab data, etc. We couldn't make the CMHC Med Manager Module do what I wanted it to do. I ended up doing essentially the same thing via the "cut-and-paste technique." The notion of concurrently doing this was catalyzed by our involvement with David and Scott Lloyd, who urged us to consider this additional refinement.

Let me describe how we operate in Medical Services:

I sit sideways to my desk, facing the client, with the keyboard in front of me on my desk, and the monitor on my desk, turned slightly toward me, so I can see it

better, but easily turned so the client may see if they wish, making a point of sharing it with them when we need to share data. I often type while one or the other of us is talking, (I can type quickly, without looking, and while talking or listening) and often say out loud what I am writing, especially when writing down the client's words – "the voices are louder, do I have that right?" or when documenting a treatment plan – "We'll raise the meds to 10 mg and meet in 2 wks, right?" Usually once the essential details are entered, not much more typing will be needed till the end of the session. The general tone is one of documenting important issues and making sure both of us are on the same page as we draw up our plan of treatment together. I don't find it necessary to warn the client "I'm going to be typing while we talk," or "this is how I take notes." I just go right ahead.

The cut-and-paste technique is a way of pulling forward clinical data from progress note to progress note efficiently, including other meds and medical problems, weights, consents, AIMS tests, labs, general overall clinical impression and plan, and documentation of exactly what I have prescribed or dispensed. (This is very useful for nursing staff when clients call about refills.) Using our network and the CMHC program, opening the new event, opening the old event, cutting and pasting the content from the old event takes 20-25 seconds per case. This provides the opportunity to look at notes from other clinicians (like reviewing the paper chart.) My new note will use the old note as a starting point, and more than half of the note is data that is the same from session to session (med lists, dates of consents, etc.) Usually writing the new note only requires a few sentences.

Closing, electronically signing, and putting through the bill take another 15 seconds or so. This can often be done as we are parting, client is putting their coat on, etc. When the client's hand touches the door, the clinical work, documentation and billing are complete. Sometimes the clinical setting does not permit this, and I will take a minute or two after the client has left to complete the documentation. For me, this is about 15% of the time, for some of our psychiatrists it is most of the time, though almost always before the next client is seen.

Staff acceptance - I began encouraging other psychiatrists to concurrently document, with the carrot of avoiding hours of paperwork at end of the night. Varying levels of receptivity were the rule, though some clinicians were already computer-savvy and interested – now all psychiatrists do some form of concurrent documentation. Eventually, based on this experience and that of other facilities, our center made concurrent documentation a matter of policy for all clinical staff, not just psychiatrists, as of 3/1/06. Varying levels of compliance and implementation exist throughout the organization, but efforts toward implementing concurrent documentation are expected in every clinical program, and some solutions are still evolving. Most concerns have been expressed by older clinicians, who fear the intrusion of the computer into the therapeutic

process, or who feel that they are "taking up the client's time" by documenting during the session. Most, but not all, therapists have grown quickly accustomed to the process. Unlike the situation in many centers, psychiatrists have taken the lead in the acceptance of concurrent documentation at Southlake.

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.

Effects on clinical work - The concurrent documentation process has, I believe, some positive effects on clinician's attitudes and performance with clients. Writing the note in such a way that it is acceptable to the client's regular perusal calls for tact, but it is possible to write, "Client is upset about changes in meds," rather than "Client continues to be impossible to please," with no loss of meaning. I find the need to avoid judgments of this kind helps me to better maintain the necessary therapeutic stance with difficult clients. As well, when the documentation goes quickly, I feel have more time and energy to spend with the client. I find myself thinking, "Oh, I don't have to write anything down today."

Quality of life issues – when my patient day is done at 8:00, I turn the key in the office door at 8:00, with all my clinical work and billing done. Even on very busy days, there is the sense of being caught up as one proceeds with the next clinical task, not the panicky feeling of being buried deeper and deeper in a pile of paperwork that will have to be sorted out later in the evening.

Effects on practice style – surprisingly, rather than lengthening my average session, I have found that I am seeing clients for briefer sessions. In my setting, a CMHC, this is not undesirable and makes it possible for me to provide services to a larger number of clients in the same period of time, which is needed. I was recently forced by an unexpected staffing problem to cover the caseload of one of my staff psychiatrists, and was able to care for a large number of clients, that would have been impossible to manage using the old system.

Effects on documentation completeness - As of March 2005, there were 143 missing progress notes in our outpatient Medical Services department. As of March 2006, after the implementation of concurrent documentation, there were 4 missing progress notes.

Center support for concurrent documentation – In a number of staff and supervisor training sessions held through late 2005 and early 2006, staff were educated and trained in the process of concurrent documentation, and were

informed both by their supervisors and clinical directors, as well as by email, that this would be the expectation for their practice. A number of challenges arose:

- Group services
- In-home services
- In-school programs

Southlake demonstrated administrative support for the practice in a number of ways.

- We purchased laptop computers for case management and for in-school staff, and have piloted the use of wireless Internet cards to permit concurrent documentation where a ground Internet connection not available.
- All clinical staff offices were visited to assess fitness for the use of concurrent documentation with our existing desktop equipment, and all staff offered help with rearranging furniture, computer connections, etc, in order to facilitate this.

- Even more creativity was needed to help our Partial Hospital staff comply with the concurrent documentation directive – eventually they figured out a way to reconfigure the therapy day so that at the end of the day, the treatment staff person would have a group with all those clients whose documentation they were responsible for, and would be able to complete the summary of the day's activity with the client present. There were significant logistical problems with equipment for this program – an attempt at wireless connection was not successful. We realized that the extra desktop computers left over when the case management staff in another program were issued laptops for **their** concurrent documentation program could be used for this, along with movable computer carts purchased years earlier when desktops were in short supply. This made is possible for us to successfully outfit the Partial Hospital staff at no additional expense in computer equipment.

Monitoring of practice – It has been a fairly simple matter to monitor the use of concurrent documentation via the use of the CMHC Enterprise View module – the supervisor may follow the progress through the day of a clinician's work, and see if their documentation is being done concurrently by monitoring the completion of notes and billing, which are posted on Enterprise View in real time.

Commitment to the practice - While hiring good psychiatrists is always difficult, I began to have problems with hiring psychiatrists who weren't comfortable with computers, or who couldn't or wouldn't type – I finally stopped trying and have made the decision that this is a prerequisite for work here, even though this has meant turning away some promising older candidates.

Limitations: I still would like a note that would do the cut-and-paste for me, and have a complete list of prescribed meds – we may be linking to an e-prescribing

package that may provide this functionality soon, though several such programs have blown up at a late stage of introduction.

. Positive impacts of concurrent documentation include:
- Improved timeliness of billing and supporting clinical documentation.
- Improved quality and usefulness of clinical documentation, especially for psychiatrists, in terms of monitoring drug interactions, consents, laboratory tests, medications prescribed.
- Reduction in time spent in documentation, especially using the cut-and-paste technique.
- Increased involvement of clients in the treatment planning and documentation process.
- Improvements in therapeutic interactions necessitated by clinicians being forced to clarify their impressions and therapeutic interventions in order to put them into words in front of the patient.
- Improvements in the quality of work life of clinicians (less time spent documenting, being able to feel caught-up with their work most of the time, instead of always behind, being finished with work at the end of the client day.)

Of all the administrative changes we have made in recent months and years, this is the easiest to sell and to use – once the front end of concern about negative effects on the clinical interaction is addressed, it is clearly a step forward, and clinicians who become fluent with it never go back