Concurrent Documentation

Pilot Project Training

Midwestern Colorado Center for Mental Health
Standardized Documentation Team

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What is Concurrent Documentation?

Simply…it is a model of documenting the session content and process with the consumer/family "at the same time" he/she/they are still present in the session with the service provider. Basically it involves incorporating an active discussion at the end of the service encounter and documenting the information provided in the electronic clinical record (ECR).

CD allows the service provider to confirm with the consumer/family in a proactive manner:

- The goals and objectives addressed during the session
- The therapeutic interventions provided by the direct care staff
- Their feedback regarding progress made and an indication of their perceived benefit of the service.

In addition, this practice is an appropriate extension of the therapeutic interaction that could serve to focus the client/family on what just occurred in the session as well as their next steps in the process of recovery/resiliency.

This is a shift from the traditional but ineffective documentation model in which direct care staff writes a "private" note between themselves and the chart at some time after the session has finished. With CD, when the "client's hand touches the door to leave," the clinical work and documentation are complete (unless a minute or two after the client has left is needed to complete the documentation).

Why is the MHC adopting and implementing Concurrent Documentation?

Class Exercise: "Paraphrasing" or "Reframing"

Have all training participants take out a piece of paper and pen or pencil and write down this statement in their own words:

"Concurrent Documentation is a very effective quality improvement tool and a compliance strategy in response to enhanced external accountability requirements. In addition, research indicates that consumers are empowered by this process and thus take more ownership of their treatment and thus treatment is more effective."

Because this reflects a growing trend in sound and effective behavioral health care practice, the MWCMHC management is having the entire agency move forward to adopt and consistently utilize this model.

This Concurrent Documentation model will

- Set a standard among all staff to assure documentation is complete, consistent, and compliant.
- Involve consumers in the therapeutic process and recording of session content and process (review, feedback, description, insight)
- Ensure greater content accuracy b/c of reduced time between actual service and writing the progress note
- Positively impact staff by
    1. Reducing anxiety b/c of being behind in documentation
    2. Increasing staff morale and job satisfaction
    3. Enhancing staff quality of life and collective well-being
    4. Reducing staff burn-out/turnover rates
    5. Allow the agency to service an increased number of consumers/families
- Ensure compliance concerns with state and federal standards

The MHC's Concurrent Documentation Pilot Project

1. The pilot project will actually introduce two (2) new models "concurrently":

- Concurrent Documentation
- A new Clinical Formulation Model*****

2. The pilot will include selection a combined total of eleven (11) MHC clinicians and case managers along with selected consumers, and secure their commitment to utilize this process.

3. Participant introduction to and training in the model

4. Each staff participant can take stock of their offices and identify modest physical changes (furniture, longer cords, rearrangement of room configuration, etc.) that would enhance model adoption and usage during the pilot.

5. Consumer/staff participation for a six (6) week period

6. Develop and hold regular mentoring and positive peer support group for all participating staff members.

7. Collection of staff and consumers' feedback and reactions to model during pilot.

8. SDT review results and feedback.

This effort will lay the foundation for eventual agency-wide introduction of models at an MHC All Staff meeting, results of pilot project, staff testimonials and an agency-wide training and implementation of these models into staff documentation practices.

***** Notes on Clinical Formulation Model

This will involve separate training.

Clinical Formulation model will give a list of criteria that should be covered in Assessments and each DAP Note to achieve completion, consistency and compliance. The agency wants to ensure that the "Golden Thread" of "medical necessity linkage" is established and carried through in each consumer/family's ECR chart. This model will move us toward more of a "checklist" format and less of a narrative format that we concurrently use with Qualifacts. This checklist will include many, if not all of the fields seen on the Individual Progress Note attachment. Pilot will reveal agency essential ECR criteria which can be used as a "Needs & Wants" list for comparative shopping for a new ECR model or an agency upgrade to Qualifacts 5.0

Possible Barriers to Implementing Concurrent Documentation

1. Integration with current (Qualifacts) or new Electronic Case Record (ECR) program
2. Consumer and staff anxiety and resistance to change
3. Staff training needs
4. Facilities adjustments
5. Not lagging with follow-up and agency-wide implementation

Benefits of Concurrent Documentation

To the Consumer/Family:

- Involves consumer/family in the therapeutic process and recording of session content and process (review, feedback, description, insight);
- Empowers consumer/family to know and determine the course of clinical assessment, interventions and progress of therapy.
- Real time feedback will increase consumer/family "buy-in" to therapy
- Cutting out-of-session documentation time results in increased hours per clinician per year for direct service, thus serving more consumers/families.

To MHC Staff:

- Because clinicians will clarify their impressions and therapeutic interventions by putting them into words in front of the consumer/family, this enhances the therapeutic value of the session.
- Ensures greater content accuracy b/c of reduced time between the actual service and writing the progress note;
- Eliminates the staff's "treadmill" of always having to catch up on documentation of services, that is, to keep paperwork timely and accurate.
- 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.

To the Agency:

- Sets a standard for clinical formulation among all staff to assure documentation completeness, consistency, and compliance with all applicable state, federal and accreditation standards.
- Increased documentation compliance would lower likelihood of paybacks via OIG audits
- Staff's increased availability could help service clients with other payor sources and/or a larger penetration rate of Medicaid clients.
- Increased staff morale and enhance quality of life would reduce staff burn-out and turnover rates.

Initially Introducing Concurrent Documentation to the Consumer/Family

From the very first session with a new consumer/family, or starting with the next session for an already active consumer/family, it is important for the therapist to take a few minutes to discuss the consumer/family's role in treatment, including creating an accurate record of progress and problem areas. If they understand why this is important, and that they are an integral part of the process, they are more likely to concur with, then participate in the practice of concurrent documentation and not feel uncomfortable or upset by it.

You will need to develop your own "script" of what to ***initially*** say to the consumer family to introduce the ensuing practice of concurrent documentation.

The Program Supervisor in San Miguel 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."*

Your script should include the following items:

1. The term "concurrent documentation."
2. Explain this term - this is a team effort between client and service provider to create a record that documents the session content and process "at the same time" with the consumer while he or she is still present in the session with you.
3. Frame it more as an "invitation" to their participation in treatment rather than a "requirement."
4. Explain that you will be reviewing the following things as you document:
   - The goals and objectives addressed during the session
   - The therapeutic interventions provided by the direct care staff
   - Their feedback regarding progress made and an indication of their perceived benefit of the service.
5. Enumerate the benefits to their participation in this way (See benefits of Concurrent Documentation – To the Consumer/Family).

NOTE:. Please use positive terms in this script. Do not apologize for the process or say something like "The agency is making me do this." This only serves to undermine the CD process, the therapeutic value of CD, and ultimately the therapeutic relationship

Concurrent Documentation to the Consumer/Family In the Session

Your Attitude

View this not as a trial, but 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.

Setting routine is one of the best ways to get into habit. One said if you are keep doing one thing on a scheduled time for 21 days continuously, you will able to get it into your habit

"For the things we have to learn before we can do them, we learn by doing them."

Aristotle

Keep a POSITIVE ATTITUDE about this change in practice
by focusing on the benefits to your clients, yourself and this agency.

Time Usage

Direct service providers can use the first 45 minutes for the formal therapeutic encounter and appropriately conclude the formal session. The service provider can then shift the focus in the last 10 to 15 minutes of the hour to the interactive process of documenting the service with the consumer/family present.

The consumer/family MUST be present in the session in order for "concurrent" documentation to occur. If the client leaves the session, the documentation efforts do not constitute a therapeutic interaction with the client that can be included in the total length of the service encounter.

Transitioning to CD In the session

1. Use the traditional "wrap up" at the end of the session to try and transition to the documentation. This is something that many clinicians are used to doing as they try to synthesize what was done during the session and bring some closure to the process. You might say "We're getting close to the end of the session. Let's stop here and review what we talked about." The only difference is that instead of just doing a verbal recap, or writing it down on paper, it's done directly on the computer ECR.

2. 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."

3. It may not always be practical to write during the *"meat" of* a session, especially for a clinician who has a hard time with typing or writing quickly. This is why waiting until the last few minutes of the session to "wrap up" the session in writing with the client may be a good idea. The therapist can jot down by hand some thoughts that they want to remember and then transition that to the computer as they wrap up. As David Lloyd says, letting the client know that what they say is so important that you want to write it down can be a nice way to help the client understand and get comfortable with the process of you jotting down info during the session, whether by hand or on the computer.

4. Use you best judgment, discretion and trial and error. The CD technique will vary from staff to staff based on what works best for each individual direct care staff. It will be up to the clinician to set parameters as with any "wrap up"/summarizing activity. The clinician must be able to judge how much time is needed for this type of activity based on the individual client's level of functioning. Examples are

    - With a client who is very manic and has a hard time keeping to the subject, the therapist might choose not to do concurrent documentation because it might take more time and be less effective.
    - When working with a client who is very high functioning, the documentation may only take about 3 minutes.
    - Practicing with different types of clients will ultimately help the clinician to decide on time frame. If the session starts to run over, then the therapist might suggest that they need to quickly finish the wrap up, or stop where they left off and the therapist will have to do it when the client leaves. The therapist can invite the client to review the rest of the note at the next visit.
    - If new info comes up while doing this at the end of the session, then as with any session, the clinician must make a judgment as to whether that information can wait until the next session or needs to be discussed immediately (as in suicidal talk).
    - There may be clients who do have a hard time with it from time to time. If someone is very upset or in crisis, it might not be possible to adhere to this process.

Class Exercise:
Role Play 5-10 minutes of a therapeutic encounter. Then have all participants imagine they have to document wit this client. Have all training participants take out a piece of paper and pen or pencil and write down what they might put in their DAP Note. What kinds of problems might they anticipate with a client or session like this in relation to concurrent documentation? Facilitate discussion.

CONCURRENT DOCUMENTATION CASE STUDY #1

Southlake Mental Health Center

By John Kern, MD, Medical Director

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 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 – Staff and supervisors were educated and trained in the process of concurrent documentation in training sessions held through late 2005 and early 2006. Staff were informed both by their supervisors and clinical directors that this would be the expectation for their practice. Some challenges arose including (1) Group services, (2) In-home services and (3) 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.

CONCURRENT DOCUMENTATION CASE STUDY #2

The Mental Health Center of Greater Manchester (MHCGM)
By David Lloyd
Accountable Care and The Success Oriented Services Change Initiative:
The Mental Health Center of Greater Manchester Experience

Accountable Care Change Initiative - Phase I

During the first phase of the Accountable Care Change Initiative, the Management Team recruited 52 staff members that included managers, line, and support staff to form 4 work teams. The team focus areas were:

- Standardized Documentation Team
- Performance Standards and Revenue Team
- Enhanced Cost Efficiency, Compliance and Outcomes Team
- Organizational Support Team.

Each team was assigned a set of change "deliverables" to achieve within certain time frames. The work teams met frequently during the first year Phase One period, and all 4 work teams met together every few months to update each other on progress with deliverables. The focus of the work teams during this phase was to review the systems and processes that The Mental Health Center of Greater Manchester (MHCGM) had in place which support the clinician's ability to provide direct care to clients. During Phase I, MHCGM also implemented productivity standards set forth by the Performance Standards and Revenue Team. Competency- based performance appraisals began to be used agency-wide. The Organizational Support Team surveyed agency staff about staff workplace satisfaction, recruitment and retention. The Enhanced Cost Efficiency Team developed a consumer satisfaction survey and a standardized system for surveying consumers.

To support enhanced performance standards for staff, Teams reviewed each piece of paperwork that was required of clinicians, and revised forms to include only the necessary information. As much as possible, standardized forms were designed to be used center-wide. Team members piloted the new forms/processes, and revisions were made based on their feedback. Once all the revisions were complete, training was provided to staff on how to use the new documents.

During these trainings, the team encouraged staff to document services during the direct care sessions, with client participation. Client signatures were not required on progress

notes, but this practice was encouraged during the pilot period. The mix of direct care staff involved in the Phase I program was 50/50 clinic based and community based staff.

Leadership Implementation Model

MHCGM provided an excellent Leadership Implementation Model for its staff. The basic tenets of the Leadership Implementation Model versus the alternative Mandate Change Model are:

- Create among all stakeholders a better understanding of how complex documentation requirements under Medical Necessity qualitative audit standards can be effectively accomplished with the client/family present.

- Reduce anxiety regarding the shift to a concurrent documentation model by sharing examples of how the model is working.

- Provide a mentoring environment by identifying barriers to a concurrent documentation model and action objectives used to overcome the identified barriers.

- Identify and communicate benefits of the concurrent documentation model based on enhanced client satisfaction/involvement, compliance with documentation submission and billable hour standards and improvement in the quality of life for staff

- Shift the focus from ***what individual staff will lose*** in order to implement the concurrent documentation process to w***hat individual staff can gain*** by using the concurrent documentation process as a tool to facilitate a more quality-based compliant documentation environment.

To support the Leadership Implementation Model, toward the end of Phase I, MHCGM had a "Town Meeting" that all staff were invited to attend. During the Town Meeting, David Lloyd, National Council Consultant, facilitated a panel of 6 direct care staff from various departments providing services in the office and in community settings. Each panelist shared their experiences on how the concurrent documentation process had worked for them, the barriers they met/overcame, and gave tips about how other clinicians could implement the concurrent style of documentation for both clinic and community based service delivery. The Town Meeting was also very important to help staff not involved in the Phase I concurrent documentation process to focus on the benefits to the clients and to staff.

At the end of Phase I, approximately 18 months after the beginning of the agency's change initiative, the management team reviewed progress, and set forth new goals for Phase II.

Accountable Care Change Initiative - Phase II

Accountable Care is one very important aspect of our "Success Oriented Services" approach. With this in mind, MHCGM embarked on the second phase of the change initiative. The Phase I work teams gathered together for one final meeting and based on the outcome of the deliverables that these teams were able to achieve, the mission and goals for Phase II were redefined for each of the new Phase II teams. Some of the staff who were part of the Phase I teams were not members of Phase II teams and staff who had not participated in Phase I were invited to be members of teams in Phase II. The 4 Phase I work teams were reduced to three teams:

- Standardized Documentation Team (SDT)
- Performance Standards, Revenue and Cost Efficiency Team
- Public Relations/ Communications/ Marketing Team.

Phase II was structured operationally to function similarly to Phase I. The three work teams met individually to achieve their deliverables. Quarterly, the entire groups of teams met to review progress.

The Standardized Documentation Team

One of the changes made on the Standardized Documentation Team was that all members had to be willing to participate in the concurrent documentation model, and to develop the agency plan for electronic medical records implementation. Emphasis on concurrent documentation had been a top priority for the SDT. A team of "internal promoters" (comprised of SDT members and other clinicians who utilized concurrent documentation) was developed to support an increase in the number of direct care staff who document in session through positive peer support, mentoring and education. Additionally, outcomes identified from the pilot program have been shared with all staff such as:

- Direct care staff who were committed to the concurrent documentation model felt (except in the case of some community based services or crisis visits where it was not indicated) that the concurrent documentation model ***actually improved the therapeutic relationship***. Concurrent documentation validated what the client said, included client in reviewing and summarizing the session and the plan for the next service. The staff members who were not doing concurrent documentation were the ones who said it detracts.

- ***Improved internal audits*** for staff using the concurrent documentation model

- For staff using the concurrent documentation model fully there was a ***dramatic improvement in their quality of life***. Others were at varying degrees of struggle.

Many staff found it challenging to utilize concurrent documentation in community-based settings, especially when issues of privacy emerged or when children were seen without their parents present.

As a result, 3 new Leadership Implementation Model support components for the concurrent documentation model have been implemented at MHCGM:

- New employee orientation now includes a module on concurrent documentation

- Added concurrent documentation to standardized Supervision logs to keep the topic alive for both supervisee and for supervisors (to encourage supervisors to assist in removing barriers to concurrent documentation)

- The Phase II Participants are in the process of making some "role play" videos, one to address each of the perceived barriers that other staff have expressed (i.e., "Its not ethical to bill for therapy while you're doing paperwork"; "It's too hard to stop the flow of conversation and start writing", etc.).

Finally, new and continuing deliverables were also established for the other two work teams, which include ensuring productivity standards were fair, making revisions to the performance appraisal for both clinical and non-clinical staff, and focusing on both internal and external marketing of services. Through these initiatives, MHCGM is confident that the organization will continue to provide quality, state-of-the-art services, thrive financially, and remain a leading community mental health provider.

Some Results and Reports

Reflections, experiences, observations and recommendations from individual direct care staff that have adopted the Concurrent Documentation Model at MHCGM:

1. **Linda Powers, RN, MA, LCMHC:** Writing notes during session reinforces to the client and/or parent that I am attending to their reports of progress and symptoms, and validating their concerns. As we address the goals and objectives, the client/parent realizes that I am mindful of the treatment plan, and the degree of progress is consistently being assessed.

   Documenting my observations as I observe a child play saves time. I have found that writing the ISP (treatment plan) during session reinforces the concept that therapy is a team effort between therapist and the client(s)/family. Likewise, completing the quarterly ISP Review with the client/parent in session reinforces team effort and the therapist's attention to status of progress.

   To be timely with the ISP Reviews, if a client has DNA'ed (No Show) or canceled the appointment when the review needs to be completed, I partially fill in the review with the information taken from previous documentations. At the next appointment, the review is completed with the client/parent. This way, I am able to maintain compliance with submitting the review on time.

I partially complete the Annual Assessment Update and CAFAS/Eligibility with the client/parent, confirming symptoms, concerns, family living, etc, but find it easier to finish writing the documents at another time. If an appointment is not attended immediately prior to the date this information is due, I complete the documents prior to the next appointment, drawing information from recent notes. I have probably found the transition to documenting during sessions easier than some clinicians have, because my professional experience as a telephone triage nurse and as a nurse in a pediatric office prepared me to document immediately, and during interactions. However, there are times when documenting during session is inappropriate because the intensity and/or nature of the session requires total attentiveness to the client.

2. **Ken Aubry, MSW, LCSW:** My first experience with the concurrent documentation model was about a year prior to efforts at MHCGM to streamline paper work. I was at my primary care physician's office, and at the end of the visit, he took out his mini cassette and began to dictate results. What impressed me was the way he demonstrated an obvious respect for me by the way he identified specifics of the exam and his conclusions. If I had questions, he was there to answer them.

   I had a positive feeling about the experience and then when the idea of doing paperwork started to be discussed, this image helped me to give it a try. Introducing this to clients was not very difficult. I began by asking if they would like to summarize what we discussed and in particular address what was useful for them during the session and what might have been not so helpful. I found that most were very willing to participate in the process. This worked well for the progress notes, as for other forms of documentation such as treatment plans, three month reviews, and annual clinical updates: I found introducing them at the start to their treatment made for a smoother transition and became something they would be expecting to complete as treatment progressed.

   The advantages to doing much of the clinical notes and forms in session were immediately apparent. I noticed that following a therapeutic hour, I felt different. I was not burdened to quickly write a note before the next hour began. I had a few minutes to relax, stretch a little, and had time to think about the next case. The clients felt they knew more about what went into their treatment planning and found it to be a more collaborative process.

   Finally, I would not do documentation in session if the client presented with intense feelings indicating a clear need to respond. I felt it important to validate this and turning to complete documentation would be a clear distraction.

3. **Catharine A. Main, MSW, LCSW:** I like spending time with my clients. I have more than enough energy to maintain a large caseload with high productivity; however, I could not feasibly maintain this without completing progress notes in session. I'll share with you just how I geared up and how I figured out why writing notes in session was important to me and to my clients – I actually get to spend more time with them!

   About a year ago, I heard staff talking about a book, "Who Moved My Cheese?" by Spencer Johnson, MD. I told my supervisor that I'd seen the book on sale and she asked me to pick-up several copies. I thought to myself, "It must be important!" so I read the book (one of her copies); it was an easy read. I learned that I was one of those "hanger-on-ers" – I like to cling to the old. I also learned that there were many changes looming and thought I'd better prepare myself.

Completing progress notes was one of those challenges. I quickly realized that I already completed very complex behavioral analysis in session with my Dialectical Behavioral Therapy clients. We'd complete complex chains involving the most intricate links to behavior – clients readily identify links and increase their awareness. Although they sometimes dreaded completing a chain, there was no doubt that they are tremendously helpful in finding out what's being reinforced.

They like to know that I want to know every detail, just like I was watching a movie about prompting events, time, place, thoughts, feelings, vulnerabilities, timing, consequences, etc. We needed to find patterns and themes. They like my interest. They like that I jot down every detail stating, "That's important." I'm very much in connection with my clients during those times. We are both very mindful. There's energy flowing. We know where we're going in reducing or extinguishing serious and impulsive behaviors that are sometimes life threatening. Our work is very serious and we need to remember things. How could we possibly remember without writing it down? So, the leap to writing other notes in session was not so far. Last month there was a huge reduction in my DNA (No Show) rating (13%) and, to me, that's an indication that my clients like my attention and my approach.

Frankly, I'm very proud of my productivity and the work that I do. There is no way I could see all of my clients and have high "billable hours" without efficiently completing progress notes in session. Ninety-five per cent of the time I leave work on time – I could never do that before. Staying after work hours and still not finishing my work really wore me down and I started to think, "our work as social workers is never done". The sad thing was that I accepted an almost constant fatigue. That is no longer the case and, despite our work being difficult at times, I have late afternoons and evenings to replenish.

Concurrent Documentation Consumer Satisfaction Outcomes:

A critically important component of the concurrent documentation model at MHCGM was to solicit and use the feedback from consumers/ families. Below is a brief summary of the Concurrent Documentation Satisfaction Survey evaluation outcomes for the period September 1, 2003 through August 31, 2004 which included:

- Of 927 respondents whose clinician used the concurrent documentation practice:

    1. 83.9% felt the practice was helpful.
    2. 13.7% found the practice neutral
    3. 2.3% disagree with the practice

- Of the 284 respondents whose clinician did not use the concurrent documentation practice:

    1. 31.5% felt the practice would be helpful
    2. 36.9% felt the practice would be neutral

3. 31.3% disagree that it would be helpful

Contact Information:

For more information regarding this accountable care change initiative, please contact: Jane Guilmette at (603) 668-4111 or at her email address guilmetj@mhcgm.org. Also, you may access more information at our website: www.mhcgm.org

Summary:

Community Behavioral Healthcare Centers are facing multiple ever changing challenges. Additionally, these challenges include ensuring that services provided to consumers/families are focused on recovery/resiliency, enhancing qualitative documentation compliance, the need to retain good staff, and, at the same time, facing the need to enhance performance levels of staff. The concurrent documentation model has proven to be very helpful to address these very complex and seemingly contradictory issues at the direct care level to the benefit of individuals (both consumers/families and staff) and therefore, the entire organization.

About the author: David Lloyd, author of "**How to Deliver Accountable Care**", has successfully facilitated the development and implementation of compliance based management accountability initiatives with over 400 CBHOs, regional medical centers, and primary care practices throughout the United States. He has been a featured presenter at numerous national, regional, state and local workshops and conferences. Mr. Lloyd is President of M.T.M. Services, LLC based in Raleigh, North Carolina, that specializes in providing management, training, and accountable care conversion services throughout the nation. Consult engagement scheduling and copies of his current book may be arranged through contacting the National Council at nccbh.org or by calling 301-984-6200.

CONCURRENT DOCUMENTATION CASE STUDY #2

The Mental Health Center of Greater Manchester (MHCGM)

Questions/Concerns for Concurrent Documentation

Curriculum Development and Training

Process:

1. **Is it supposed to take 5 minutes to do this? When meeting face to face with the client would you keep them for the whole hour and use the last 10-15 min. of the session to document?**

   Typically direct care staff members are using the 46 to 50 minute formal therapeutic encounter model and then appropriately concluding the formal session and shifting the focus in the last 10 to 14 minutes of the hour to completing with the client present an interactive process of documenting the service. A good introductory phrase 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."

   Also, the staff at MHC of Greater Manchester program have used the traditional "wrap up" at the end of the session to try and transition to the documentation. Saying, "We're getting close to the end of the session. Let's stop here and review what we talked about" , is something that many clinicians are used to doing as they try to synthesize what was done during the session and bring some closure to the process. The only difference is that instead of just doing a verbal recap, it's done with paper or on the computer.

2. **Is it acceptable to have 50 min. sessions and document after the client leaves? Or does it have to be done with the client in the room?**

   If the client leaves the session, the documentation efforts do not constitute a therapeutic interaction with the client that can be included in the total length of the service encounter. There are three major reasons for doing concurrent documentation.

   a. Compliance - Having the required documentation completed before the service is billed. Going even a step further and having the client sign the note as the MHC of Greater Manchester program ask clinicians to do allows for even more compliant practice.

   b. **Client recovery**- Having the client be an active participant in all aspects of their treatment, including documentation.

   c. **Time effectiveness**- Completing the notes during sessions with the client present allows for more accurate and timely documentation, instead of letting documentation build up and put the clinician at risk for error, or having to stay late to complete.

If your staff are doing the documentation after the client leaves the session, your staff miss out on at least two of the above goals.

3. How does concurrent documentation work?

Basically it involves incorporating an inactive discussion with the client/family with them present during the service encounter and documenting on paper forms and/or keying into an electronic clinical record the information provided. (Review the Concurrent Documentation Case Study developed by David Lloyd for further information).

Also, from the very first session with a new client, or starting with the next session for an already active client, it is important for the therapist to take a few minutes to discuss the client's role in treatment, including creating an accurate record of progress and problem areas. If clients understand why this is important, and that they are an integral part of the process, they are more likely to participate in the practice and not feel upset by it. There may be clients who do have a hard time with it from time to time. If someone is very upset or in crisis, it might not be possible to adhere to this process. Once the therapist has explained the process to the client, he/she can proceed with completing the documentation (See #1).

4. How do you type and speak at the same time without having the client/family feel as though you are ignoring them?

Some of the techniques used are:

- **a.** Discuss the approach of involving the client/family in the documentation process at the beginning of services to gain their understanding and concurrence (Review the Concurrent Documentation Case Study for further information on approach with clients/families at the beginning of service).
- **b.** Indicate to client/family, "What you shared is important, I want to capture this information"
- **c.** Provide training for staff to become more proficient at typing without having to look at the key board on a constant basis.

It may not always be practical to write during the "*meat"* of a session, especially for a clinician who has a hard time with typing or writing quickly. This is why waiting until the last few minutes of the session to "wrap up" the session in writing with the client may be a good idea. The therapist can jot down by hand some thoughts that they want to remember and then transition that to the computer as they wrap up. As David Lloyd says, letting the client know that what they say is so important that you want to write it down can be a nice way to help the client understand and get comfortable with the process of you jotting down info during the session, whether by hand or on the computer.

5. Will there be flexibility about when and when not to use this method?

Response: The use of clinical judgment to effectively determine on a case by case and event by event basis when the concurrent documentation is very appropriate. The Concurrent Documentation Case Study provides several identified instances where the model does not work for some staff. However, it is important for a clinician to give it a good try before determining that it can't be done. When first beginning this process, clinicians might have a lot of anxiety around it. Clinicians should be aware of their own feelings about the process so that they can be as successful as possible. If a client becomes very upset or paranoid by

concurrent documentation, then the clinician may want to stop the practice for that session. At a calmer moment later in, or at the end of the session, he/she can go back and revisit whatever the client's reservations are and see if there is a way to address their anxiety around the practice to help them become comfortable with it.

6. **Are there standards and procedures that really work?**

   Response: Refer to the Concurrent Documentation Case Study for further information.

   Additionally, each clinician develops his/her own style when doing concurrent documentation. Through practice, clinicians tend to become more and more comfortable with the process and are able to develop a style and routine that works for them.

7. **Do you do this documentation in the client's home? Do you document as you go along? Concern that clients will feel intimidated by this.**

   Response: Yes, documentation in client's home is very appropriate for so long as you have discussed this process with client as a helpful way to ensure understanding and agreement for the service interventions provided, the client's response to the interventions and progress achieved or lack of progress due to identified barriers and a plan to overcome the barriers. It has been determined from in home direct care staff using the concurrent documentation model that it may be inappropriate to use concurrent documentation if the client/family is in crisis. Again, clinical judgment will need to be used to assess each situation.

   Many of the community-based therapists at MHC-GM use the practice of concurrent documentation in the home. It works the same way as it does in the office, only the therapist might need to have some sort of clipboard if handwriting, or PDA/ portable computer if using electronic med record.

8. **What are the benefits of this process?**

   Response: Review the Concurrent Documentation Case Study for the identified primary three benefit areas:

   a. Enhanced quality of life for staff based on staff feedback using the concurrent documentation model. The key benefit in this area is being able to finish documentation work daily and go home without the anxiety of being behind/needing to catch up.

   b. Enhanced compliance with documentation completion standards in that documentation is completed and submitted at the end of the service.

   c. Client satisfaction and enhanced engagement in therapeutic process based on client satisfaction surveys from other MHCs using the concurrent documentation model (refer to the concurrent documentation case study provided)

Also, #2 above also addresses this issue.

9. **There is a concern that sessions will go overtime with trying to get documentation done with client still present. Suggestions on how to keep the session from starting all over again when summarizing at the end of the session and new comments and info come up?**

   Again the technique will vary from staff to staff based on what works best for each individual direct care staff. It will be up to the clinician to set parameters as with any "wrap up"/

summarizing activity. He/she must be able to judge how much time is needed for this type of activity based on the individual client's level of functioning.

For example, with a client who is very manic and has a hard time keeping to the subject, the therapist might choose not to do concurrent documentation because it might take more time and be less effective. When working with a client who is very high functioning, the documentation may only take about 3 minutes. Practicing with different types of clients will ultimately help the clinician to decide on time frame. If the session starts to run over, then the therapist might suggest that they need to quickly finish the wrap up, or stop where they left off and the therapist will have to do it when the client leaves. The therapist can invite the client to review the rest of the note at the next visit. If new info comes up while doing this at the end of the session, then as with any session, the clinician must make a judgment as to whether that information can wait until the next session or needs to be discussed immediately (as in suicidal talk).

10. How do you facilitate a CFT meeting and type/document at the same time? If typing while listening to team members, chances are only half of what is being said will be heard and details will be missed. On complex CFTs such as those with larger number of members and are high maintenance with volatile relationships a scribe would be needed. Who would that be?

The amount of documentation during the meeting by the facilitator is dependent on the complexity of the CFT. For example, if the CFT consists of parents, child and therapist the concurrent documentation process would be the same as for the therapy progress note done in collaboration as a summary.

Concurrent documentation during a complex CFT meeting could be done by one of the following:

1. At the site, a FSP, FC/BHT, Therapist, Clinical Consultant, CFT Coach or any other JFCS staff who may be attached to the team could act as scribe for the team meeting note.

2. For some youth/parents that have the capability and desire, they could type their own notes in a Word document during the meeting.

3. There are sections of the note that could be completed ahead of time or during the meeting. The majority of the documentation would be completed as part of the group summarization process before the end of the meeting.

11. What are the agency's expectations for this process? Will it be optional for staff who are already meeting productivity requirements, who don't have difficulty with time management or with completing documentation accurately and timely?

The agency's expectation is that all staff who are providing direct care and are required to complete documentation will utilize concurrent documentation as part of their standard practice. Professionals utilizing concurrent documentation have found this practice to have increased their productivity. The rationale for using concurrent documentation goes far beyond productivity and time management. Those using concurrent documentation have

been able to show that it is an engagement tool, promotes clarity of understanding between staff and clients, increases client and staff satisfaction and results in accurate documentation of treatment content.

12. **Need simpler forms for documentation so focus isn't on navigating through complex formats. For CFT notes it would be difficult to keep the note organized while running the CFT meeting due to the way the template is. Often times the writer will run out of room in the template boxes yet you have to finish all of the template before generating the document (at which point you can add more).**

    The CFT meeting note for cases that are not complex is generated off the progress note and is not complicated. There are plans to change the template for the CFT meeting note used to document the intensive cases. Suggestions are welcome for submission to the IS Clinical Team.

    At MHC-GM, as part of our Accountable Care Initiative, we reviewed all clinical forms and formatted them so that they would somewhat guide the sessions, be compliant with state standards, and have little need for "narrative" writing. Rather, check boxes are used. You may want to consider doing something similar for the forms that you use on the computer if possible.

13. **Need clarification where concurrent documentation would not be an option (i.e. if we are out taking a client to look for jobs, applying for AHCCCS, home visit with client in a group home setting). Is it appropriate to be doing documentation in a setting where other clients are around and can possibly view this info?**

    Recommend that as the pilot program progresses, that specific protocols be developed to address when it is appropriate to use concurrent documentation model. Also, it is important to ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training.

    If the therapist is meeting in a place that is confidential enough to talk, then likely it is confidential enough to write. Not all settings are conducive to therapeutic activities, whether verbal or written. MHC-GM agrees with David Lloyd that the agency policies should dictate where therapy can and can't take place. As with any protected health information, if the progress note, treatment review, treatment plan, etc. is completed in a community- based setting, then the clinician must ensure that it is safe and secure from others reading it. If it is in a computer, then a password security system is likely a safe alternative. For handwritten documents, placement in a bag that remains in the custody of the clinician can provide safe transport back to the secure medical records area.

Client Related Concerns:

1. **Are we supposed to have client feedback on this process?**

   Yes, routine surveys and feedback should be requested as a part of a CQI process.

   At MHC-GM, we have begun surveying clients about this process every quarter. Thus far, the results have been positive. Your agency may want to implement a similar process by

adding a few additional questions onto the already existing survey (Examples of the 3 questions we ask are in the case study).

2. **Are we asking the family/client what they want us to write or are we simply writing as we are speaking with the client (i.e. writing how we would normally write without their input, but just doing this with them present)?**

   The concurrent documentation model provides an excellent opportunity for direct care staff and client/family to have an interactive dialogue at the end of the service about the goals/objectives in the service plan addressed, interventions provided and the client/family response of how they can/will use the information/intervention provided in the session. Also, this response provides an opportunity for client/family to identify barriers to using the interventions provided which can be addressed as a plan for future service encounters. Based on the client/family responses, the direct care staff can identify any progress achieved during the session. Therefore, the concurrent documentation process is very interactive.

   Additionally, it is important to remember that the clinical record is a legal document and that anything the clinician writes in it may be reviewed under litigation. While this is a very interactive process, and clients can have input in reviewing the information/ review of the session, the clinician must always document ***accurately***. It is likely that most of the time, there will be agreement as to what evolved during the session, how much progress is being made, what the treatment goals will be, etc. The clinician should document anything they would normally document, while allowing the client to have input into the process as well. Under HIPAA, if a client does not agree with anything that is documented in their record, it must be reviewed. If incorrect, it may be corrected by the writer. If the information is clinically accurate, but the client disagrees with the content, they can submit and addendum to be added to the record, expressing the aspects with which they disagree and what they feel is a more accurate.

3. **What if there are clients who are completely opposed to this? As social workers, we are to value our client wishes. What do we do if they don't want us jotting down notes?**

   If specific clients do not feel comfortable with the concurrent documentation model, then direct care staff needs to support these wishes. If all clients of one staff have a concern and do not want to participate, then it is recommended that the identified staff receive re-training on the use of concurrent documentation model and its benefits by assigning a mentor to work one-on-one with staff members that have been identified as needing this training.

   Most of the time, clients are perfectly fine with this process. It is used in all aspects of healthcare these days, and as clients become more accustomed to it, they will likely have little trouble with it. But MHC-GM does agree that if someone is vehemently opposed to the practice, it should be avoided. It is difficult to have an hour long session and remember all of it without jotting down some notes. MHC-GM thinks clients realize this and if explained to them in a practical way, even if they are initially opposed to it, they might feel better about it if they understand why it's important.

4. **When clients have situations they don't want documented, should we not document the comments as requested? Would like some suggestions of other ways to note or re-state the information that may be acceptable to client.**

   Ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training. A basic principal of documentation is to document only what is necessary. This usually includes those areas necessary to meet the payor requirements, state compliance standards, and capture the essence of how the client is progressing, risks, services provided, etc. If the client is opposed to using the word "hallucinations" for example, the clinician might choose to use a direct quotation to express what the client has revealed (i.e. Client reports, "I keep hearing voices telling me that I am bad"). Direct quotes are a good way to keep any judgmental or inaccurate information from getting into the chart. If, for example, a client says that they are suicidal and they ask the clinician not to document that, I would explain to the client why it's important that we document this information. Likely there will be other interventions involved if this is the case. If the client presses for something that absolutely should be documented not to be, then I would halt the documentation and let the client know that consultation with a supervisor is necessary. You can assure the client that only information relevant to the assessment will be included. At MHC-GM it is rare that this issue comes up.

5. **Current feedback from clients is that doing the note during the session would be uncomfortable. Reaction so far by clients has not been positive. How to present new practice to clients?**

   Ask for specific feedback and initial experiences regarding client feedback from peer direct care staff using the concurrent documentation model during the Internet based training. Also, in the case study the participating clinicians address how they "gentled" into the use of the model with clients.

   It is important to determine how much is client discomfort with this process, and how much is clinician discomfort. At MHC-GM, we surveyed both clients and staff to get a sense of the barriers to this process. Client surveys have suggested that they generally do not mind this practice, and most find it helpful. It is a major change for most clinicians and anxiety about the change is very normal. As stated in other responses, client and staff education about the benefits of this practice is needed in order to be successful.

6. **Will this process hinder rapport building with new clients?**

   Outcome from use of the concurrent documentation model does not indicate that the process hinders rapport building. Outcomes indicate that the concurrent model enhances rapport building. Encourage that is area be addressed with specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training.

   We have not found that it hinders rapport with clients if done well. The therapist will have to pay attention to both non-verbal and verbal cues from the client and assess whether this process is interfering with the therapy. If done at the end of the session like David Lloyd and MHC-GM suggest, there is a good chance that it will do more to build rapport than hinder it.

7. **How to train/transition clients who are accustomed to working with us in certain ways to having this different type of therapeutic alliance. Concern with comfort level of client.**

   Ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training regarding how they transitioned existing clients to the concurrent documentation model.

   Change is a normal part of life. Much of what we do with clients is helping them adapt to changes as they arise. The switch to using this process can be seen as an exercise in change process. Clients may be vulnerable. But they are also very resilient. As long as the therapist adequately explains the process, why it's important, how it will effect the sessions, and what is expected of the client, it is likely that the transition will be fairly smooth. The clinician can periodically check in with the client to make sure they feel OK with the change.

8. **Professional may be perceived as rude, disrespectful or uncaring by the client. Clients will think professional is not being attentive or really listening to what they are saying and will wonder what is being typed or be more focused on "what you are writing" then on what we are talking about with our clients.**

   Outcomes from other professionals using the model support the perception by clients/families that the interactive documentation model is caring and provides very useful and helpful information in a recovery/resiliency model of services. Ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training.

   MHC-GM has found that in most cases, this isn't true. If the therapist explains the process ahead of time, clients have been very receptive to the idea. Any medical professional usually jots down a few notes during a session. We have heard complaints from clients in the past because the therapist wasn't writing any notes down in the session.

   Doing the wrap up/writing together at the end of the session usually would not be seen as rude or uncaring, but as collaborate and respectful of the client's role in the process.

9. **How can it benefit the client if they will have more participation in charting and less time and involvement in the therapy itself?**

   Those using the concurrent model have experience that charting becomes an appropriate extension of the therapeutic encounter and supports the work/interventions provided in the first 46 to 50 minutes of the one hour session. Ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training.

   Documenting with a client at the end of the session does not have to mean the client is less involved in therapy. At the time when a usual review of the session would happen to bring closure to what was discussed, the therapist can use this time as an opportunity to document and involve the client in a way that he/she likely has not been involved in the past.

Clinician Related Concerns:

1. **While in session am listening and observing body language. How can I do that with my face in the computer? How to attend, listen, assess and respond in a manner conducive to rapport building and effective therapeutic processing? Process can seriously disrupt the therapeutic flow, where it will be easy to miss key elements while writing, missed opportunities for therapeutic challenge and invitations for growth-all critical aspects of the therapeutic process.**

   Typically, the concurrent documentation is done at the end of the service. However, as staff have used the process, they have expanded the concurrent documentation model to initial diagnostic assessments, etc. (Review the Concurrent Documentation Case Study for further information)

   Concurrent documentation, if done well, should not interfere with the client interaction. Rather, it should enhance it. Doing it at the end of the session, as David Lloyd suggests, is one way to ensure that the therapeutic process is preserved. Certainly, any of us would feel upset if we went into a therapy session and our therapist was turned away and looking into the computer. Concurrent documentation doesn't suggest that this be done. For assessments, evaluations, consults etc, where lots of questions are being asked, it is definitely possible to document during the session even into the computer. Many primary care physicians do that in their practice, and it is fine to do, as the process is more "information gathering" than therapeutic intervention. Explaining the process to the client ahead of time and making sure to have a respectful rapport with the client when the question is being asked can go a long way in helping them to feel comfortable with this.

2. **How do you use when there is a lot of critical emotional work or trauma work being done? Instances where concurrent documentation may be inappropriate or cumbersome such as crisis situations, trauma or grief issues with clients, using expressive modalities (art or play therapy), groups. How to apply or not apply practice in these situations?**

   Ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training.

   As stated in previous responses, this practice might not work in all situations. The clinician needs to use discretion and clinical judgment. MHC-GM does lots of work with trauma recovery and with individuals who are highly emotionally unregulated. Two of the clinicians on the panel work in a program to treat this type of population. They will be able to give further insights during the training as to how this process works for them.

3. **Will there be times when it isn't feasible to use-Domestic violence work such as accompanying a victim to court or to a DES appt, facilitating a group?**

Recommend that as the pilot program progresses, that specific protocols be developed to address when it is appropriate to use concurrent documentation model. Also, it is important to ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training. See above.

4. **Victims of DV are incredibly fearful of having things written down because of nasty custody disputes, divorce, fear of retaliation by abuser if s/he gained access to records. How to approach and use this process with this special population? How to apply this process and build trust in situations where client is telling his/her victim story and often distrust of people in general is present?**

   Recommend that as the pilot program progresses, that specific protocols be developed to address when it is appropriate to use concurrent documentation model. Also, it is important to ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training.

   Special populations may need to be handled differently. Whether or not the client knows about it, you will be documenting important aspects of the session. It may actually help the client to gain trust if she knows what is going into the record and has some input into it. The difficulty might be if the client does not want anything recorded. Reviewing agency confidentiality procedures might help to allay some fears. It is important to educate clients at the start of treatment and then periodically about the circumstances when a record can be released. In most instances, client authorization is required. However, even without client authority, a court order or other legal mechanisms may be invoked to gain access to the record. These are reasonable fears especially when the client has been victimized. The clinician will have to be very sensitive to the client's needs and may even ask the client at the start of the session for permission before attempting to document in the session.

5. **How does this impact working with children when the parent and child are not seen together, who reviews the note? How does this affect hard won confidentiality with some children? How to handle situations if child is too young to review the note, when it is not appropriate to share note with GH staff, note contains information the child is not ready or prepared to know? How to use in 1:1 visits with children?**

   Ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training.

   As with other special populations, discretion must be used when working with children. Our practice has been to decide on a case by case basis when and how this should be used. If the client is old enough to read well, and if emotionally appropriate, the clinician will often review the note with the client. If parents are there, then they might sign the note. We usually don't have the child sign the note unless they are adolescents. Two of the panel members work with children and will be able to be able to speak more about their experience with this during the training.

6. **Fear that when professional is documenting concerns about safety or risk in a Child Protective Services case, that the client won't understand what the professional needs to document and why.**

   Education is the key to success in the area of helping clients understand when your agency is and isn't able to keep the information they tell you confidential. Many clinicians have found that working collaboratively with a client or family yields the best results for rapport and trust

building. If a protective referral needs to be made, the therapist might let the client know what their fears are and why you are obligated to report what they just told you. This can be a very sensitive subject, so concurrent documentation might not be appropriate. Again, much of this depends on the clinician's discretion.

7. **How to apply this process to group work? If documenting at the end of a group session and I am not a fast typist, how to make it seem effective without making the students feel pressured or like they are taking a test? Need strategies for how to use in group work. How do you use for a pre-teen social skills group that requires undivided attn at all times or for a teen anger management group where confidentiality is a concern-how do you document for these types of groups since they process/care more about what is written about them? How to do this and run a group of 5-9 yr. olds who need CONSTANT supervision.**

   Ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training.

   MHC-GM has found that most of time concurrent documentation for group interventions isn't possible.

8. **Will lose opportunity for much needed down time with the decrease in admin. Hrs. that are set aside for documentation upkeep/crisis documentation.**

   Protocols will need to be developed to accommodate direct care staff's appropriate needs for down time outside the sessions.

   At our agency, there is some non-clinical documentation that has to be done and isn't appropriate to be done in sessions. There will likely still need to be time set aside for that type of paperwork. However, completing anything that CAN be done in session within the session helps clinicians document accurately, stay compliant with billing practices, and keep ahead of clinical documentation instead of always being behind. Clinical directors should keep in mind the need for clinicians to periodical "refuel" and develop agency procedures that address this issue.

9. **Sessions not as intense, client not willing to open up or work as hard knowing that work is going to be recorded in a written document. Therapist will ruin the moment with statements like, "Ok, how should we write that in your note?" Concern that transition will promote wasted opportunities for growth.**

   Ask for specific feedback from peer direct care staff using the concurrent documentation model during the Internet based training.

   MHC-GM has not found this to be the case. Many of the responses above speak to this issue.

10. **Clinician needs time to collect thoughts before documenting.**

    There may be times where a client is so scattered, pressured, delusional, etc. that some time may be needed in order to accurately document the client's presentation and content of the session. However, in many instances, the clinician can document at the end of the session

with a client with little difficulty. As stated previously, the more experience clinicians obtain with this process, the easier it becomes.