The Golden Thread: Weaving Together Treatment and Collaborative Documentation

Presented by:
Katherine Hirsch, LCSW, M.T.M Clinical Consultant
M.T.M. Services, LLC
Phone: 630-301-0554
Email: katherine.hirsch@mtmservices.org
Web Site: mtmservices.org
Does this look familiar to anyone?
Objectives for today....

• Recognize how collaboratively documenting during assessment, treatment planning, and ongoing treatment can be utilized as a clinical tool that follows the golden thread and supports Client Centered Treatment.

• Recognize the Golden Thread and how every service provided should link back to the assessment through the treatment plan and how CD assists in this process.

• Recognize benefits and obstacles for organizations when transitioning to a Collaborative Documentation model and how to best manage and support staff during this transition.
Objective:
This no longer looks familiar to anyone!
Simple Question

If you ask individual why they are coming to see you....

What percentage will know?

If you ask individual what their specific current Goals and Objectives are...

What percentage will know?
What Do We Do?

Our Mission is not to Care About Our Clients!

That’s something we need to do to accomplish our mission...
What Do We Do?

Our Mission is not Just to See Lots of Clients!

That’s something we need to do
to stay viable ...
What Do We Do?

Our Mission is to Help People Recover!

*If our documentation processes don’t help us accomplish our mission we are missing an important opportunity and wasting time!*
Documentation has Become “The ENEMY”

Clinicians report that documentation competes with time spent with clients

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

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

Clinician’s paperwork and clinical work are divided. (We stop, think, recall and write what we remember and what we think or hope the client experienced during the session.)
Re-Integrating Clinical Practice and Clinical Documentation

Goal is to integrate documentation and the clinical process
Re-Integrating Clinical Practice and Clinical Documentation

In order for us to integrate documentation and the clinical process we need to stop thinking of clinical documentation as “paperwork” and start seeing it as part of the clinical work we do!
What is Client Centered Treatment?

> Client Centered Treatment is a process in which providers and clients (including family unit) collaborate about treatment needs, obstacles, goals and progress.

> Clients are consistently reviewing progress made toward treatment outcomes.

> Treatment needs are consistently evaluated and plan is adjusted as needed to reflect treatment needs.

> The Client must be present and engaged in the process of documentation development and providing ongoing feedback and input about treatment needs and achievements.
Client Centered Treatment and Collaborative Documentation go Hand in Hand

• Client Centered Treatment supports the client/ family unit being involved in identifying treatment needs, developing a client friendly treatment plan and assessing progress along the way.

• Collaborative Documentation is a clinical tool used to assist and support staff in maintaining Client Centered Treatment
Collaborative Documentation (CD) is Utilized to Support Client Centered Treatment:

- CD is a clinical tool that provides clients the opportunity to be an active participant in completing all documentation. This is a client centered model that provides the client/family the opportunity to provide their input and perspective on services and progress, and allows clients and providers the opportunity to clarify their understanding of important issues and focus on outcomes.
Where is the **Golden Thread**?

Golden Thread

Assessing with The Client
- Completing the Assessment Form

Planning with The Client
- Completing the Service Plan

Working with The Client
- Writing Progress Notes

Shadow of Golden Thread - Documentation Linkage
The Golden Thread, Client Centered Treatment and Collaborative Documentation
ALL Work Together

Assessment Data:
Complete with the client to ensure there information is accurately stated in document

Diagnoses – Strengths – Personal Goals - Assessed Needs

Discuss current symptoms, triggers and functional impact at home, school/ work and community. Identify strengths, personal goals and current treatment needs.

Service Plan Goals
Develop treatment goal that reflects on what client wants

Interventions and Services
Discuss interventions that will be provided and recommended services

Interactions Directed by Service Plan
Complete Progress notes during session wrap-up and review treatment progress.
Link session to session by reviewing previous weeks plan at beginning of the next session
Collaborative Documentation

What you do is important!

Collaborative Documentation Needed to Support:

- Timely communication with other providers (e.g. treatment team, integrated physical health partners, etc.)
- Care coordination and risk management
- True “informed consent” for sharing of information
- Increased clinical capacity needed for:
  - Rising productivity standards
  - Open/ Same Day Access
  - Centralized Scheduling
  - No show/cancellations and backfill management
CD vs. Post Session Documentation

Time Savings

• Transitioning from Post Session Documentation Model to Collaborative Documentation Model gives you back valuable time to do what you were trained to do.

• Example: Staff that are taking 10 minutes to write a progress note are using approximately 400 hours a year just for all documentation.
CD vs. Post Session Documentation

“It’s not fair to clients – they will resent doing paperwork!”
Collaborative Documentation Pilot Client Survey Results

1. On a scale of 1 to 5, how helpful was it to you to have your provider review your note with you at the end of the session?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Percentages</th>
<th>Total</th>
<th>Total %</th>
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<tbody>
<tr>
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<td>4%</td>
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<tr>
<td>2 Not helpful</td>
<td>299</td>
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<tr>
<td>3 Neither helpful nor not helpful</td>
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<td><strong>Total/Approval %:</strong></td>
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<td><strong>94%</strong></td>
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2. On a scale of 1 to 5, how involved did you feel in your care compared to past experiences (either with this or other agencies)?

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<tr>
<th>Rating</th>
<th>Percentages</th>
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<tr>
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<td><strong>97%</strong></td>
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</table>
Collaborative Documentation Pilot Client Survey Results

3. On a scale of 1 to 5, how well do you think your provider did in introducing and using this new system?

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

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<tr>
<td><strong>Total/Approval %:</strong></td>
<td>22,676</td>
<td>94%</td>
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Collaborative Documentation As A Clinical Tool

- Documentation transitions from something staff are expected to get done by the end of the day to something they want to complete with the client and more importantly, that the clients wanted to complete with staff.

- CD encourages a review of the session which leads to clarification of client benefits and addresses misunderstandings that might occur during the session before the client leaves.

- Many clients express feeling heard and indicate that they like knowing what is written in the chart.

- Clients responded to structure of the end of the session.
Collaborative Documentation As A Clinical Tool

- The Plan was a much more powerful section when completed with the client.

- Tasks or skills that the client had agreed to try were noted and reviewed at the beginning of the next session. *(What is the client going to do)*

- Tasks that I agreed to complete were noted and reviewed at next session as well. *(What is the staff going to do)*

- Topics that we did not have time to address. *(What are we going to do together at the beginning of the next session)*
CD Requires a Shift in Thinking

- We need to stop thinking of clinical documentation as paperwork and start thinking about it as the clinical work.
  - Remember your attitude about Collaborative Documentation will impact your success.
- Be prepared to be more transparent as a provider!
- Be prepared to decrease how much you are writing. A great note does not mean a long note!
- Remember that it is OK to Agree to Disagree!
  - One common fear among service providers is that clients will resent or disagree with what is being documented.
  - Experience demonstrates that clients accept that providers need to document their observations and perspectives as long as the clients’ and/or parents perspectives are documented as well.
Shift Your Language

Be prepared to **shift your language** to client friendly language that will still maintain medical necessity.

- Using technical terminology can negatively impact treatment
  - Use clients language and terms that client can understand and/or relate to.
    - Clinical words can be a trigger for some clients
    - Using language that the clients do not understand interferes with collaborative process
    - (Ex: Instead of using word isolation, indicate how client is isolating. Client is spending all day in room and does not want to interact with others in the home.)

- Use quotes to describe symptomatology
  - Client stated, “I feel sad all day and that is why I do not want to be around other people. I just feel like crying and sleeping.”
The Golden Thread, Client Centered Treatment and Collaborative Documentation all Work Together

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

  —Client Centered Treatment

  —Engagement

  —Medical necessity

  —Maintaining Outcome Focus
Collaborative Documentation: Intake/Assessment

Know your assessment instrument!

Introduce the plan for the meeting including how you will work Collaborative to accurately represent the information they are telling you today.

2 Ways

- **The great typist** can type while he talks and review before moving on to next section.

- **The limited typist** can talk and the review and type before moving to the next session.
Collaborative Documentation: Intake/Assessment

Complete one content section at a time
• Discuss the section with the client/family
• Enter into system allowing client to see and comment/clarify
  – Presenting Problem
  – Psychiatric Hx
  – Family Hx, etc....

Diagnoses:
• Talk with client about their symptoms, what diagnoses really are and then share your current conclusions and document with client. Use the symptoms they describe and the data from DLA 20

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

Identified Needs/Problems
• Develop clearly identified and prioritized Behavioral Health Needs (Problem Areas) that can be used to establish Goals.
• This will be the link from the assessment to the goal.
Treatment Plan

Goals:

- **Definition:**

  A Goal is a general statement of outcome related to an identified need in the clinical assessment.

- A goal statement takes a particular identified need and answers the question, *What do we want the outcome of our work together to be, as we address this identified need?*

- Discuss and enter a collaborative statement that makes sense to the client.

- Incorporate personal goals when possible with behavioral health goals.
Objectives:

• Attempt to develop a measurable and observable outcome that:
  ➢ Will be **apparent** to the client
  ➢ **Meaningful** to the client
  ➢ Achievable in a **reasonable** amount of time
  ➢ Can be assessed in an **objective** way

• Objectives are important to allow you and the client to tell if the work you are doing together is working.
Treatment Plan Interventions and Services

- **Interventions**
  - Discuss the Intervention(s)/Strategy(s) that will be used to help achieve the objective.
  - Document with the client. Help them understand that this is what you will do to help them walk up the staircase.

- **Services**
  - Discuss the modality/service that the intervention(s) will be provided in as well as the planned frequency and duration.
  - Review recommended frequency and confirm what they are able/willing to commit to.
Treatment Plans Set the Stage for Collaborative Documentation of Progress Notes

- Having Useful Treatment Plan Goals and Objectives makes collaborative documentation of progress notes easier in terms of:
  - Compliance – Need to relate sessions to treatment plan
  - Engagement – Assessing progress helps engage and encourage clients
  - If treatment plan becomes irrelevant – update it!
  - If objectives aren’t being met – what do we need to change?
Keys to Completing Progress Note

• Be aware of the treatment goals and objectives.

• Start every session by reviewing the previous weeks note (Plan Section)

• Break up the note (Many complete Mental status at beginning of the session)

• Interact normally with the client during session

• Wrap-up the session and complete note collaboratively
How do I do a CD progress Note?

Separate Progress/Service Note into “mini-sections “ and document.

1. New or pertinent information provided by client.
2. Changes in Mental Status
3. Goal(s) and Objective(s) (from current service plan) addressed
4. Describe the intervention provided (should be consistent with prescribed intervention(s) from Svc. plan.
5. Describe client’s response to intervention
6. Describe client’s overall progress re the goal/ objective being addressed
7. Describe the plan for continuing work
Collaborative Documentation:
Progress Notes (Strategy varies by service)

Basic Approach

• Start with the “Plan” from the last interaction (i.e. what will the client and possibly the provider do between sessions or what will be the focus of the next session).

• Interact normally with the client during session/interaction possibly taking notes on pad saying “I’m going to jot down a few words so we’ll remember when we write our note at the end of the session”.

• At end of session (Time usually used for “Wrap Up”) say “Let’s review and write down the important parts of our session today.”
Collaborative Documentation

Implementation
Collaborative Documentation

Keys to Successful Collaborative Documentation Implementation

• Attitude (clinician/ organization)
• Preparation
• Find a starting point
Clinician Attitude

For success, **Attitude** is equally as important as **Ability**.

Walter Scott

[www.positivemotivation.net](http://www.positivemotivation.net)
Clinician Attitude

• View collaborative documentation 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.

• If you project CD as an valuable interactive process your clients will perceive it this way also.

• Setting routine is one of the best ways to get into habit.

• Implementation experience shows that collaborative documentation will become a habit within 6 weeks.
How to Introduce Collaborative Documentation to Clients

The key is to know what you want to say:

• **Script Elements** –
  • This is *your* note/chart
  • This is *your* care
  • I want to accurately state what you are saying
  • I want to indicate what you are getting from our time together versus what I think or hope you are getting
  • *Your* opinions and feedback are very important in the development and maintenance of your treatment goals
  • We want to make each service the best for you that we can
Introducing Collaborative Documentation to New Clients

• When using CD with a new client it is important to introduce the document that is being completed that day.

• Breaking up the descriptions to each session allows the client to better understand the goal of that meeting and their role.
Collaborative Documentation with a Existing Client

• When using CD with a existing client it is important to introduce the process as something new and exciting.

• Use the documentation as you are explaining the process. Ensure that they understand their current plan and how treatment relates to the plan.

• Remind them that this is their opportunity to ensure they are getting what they need from their services.
Find a Starting Point to Transition from Post Documentation to Collaborative Documentation

“Do As Much As You Can” approach

(And/Or “Do As Much As Your Client Can”)

a. Set your goal of completing CD at least 93% of the time
b. Set objectives to meet this goal
c. Make the objectives for yourself measureable and obtainable.
d. Determine what you need to support you in achieving your objectives.
e. Remember not to let the exception become the rule
Technology

• Technology is great when it works but you must always have a back-up plan.
  
  — Plan A: Have connectivity to EMR or system that allows syncing later
  
  — Plan B: No Connectivity – Can use E-forms then copy/paste.
  
  — Plan C: Use paper forms then type into E-Forms
Collaborative Documentation Setup

How to Make it Happen:

• **Scripts** – Know how you are going to explain the process to your clients before your session.

• **Office Setup** – Do you need to move computers, screens, office furniture?

• **Technology** – Technology is great when it works but you must always have a back-up plan.

• **Do as much as you can** - Completing a portion of the note in session as you are starting out is okay; simply move to do more each time.

• **Clinical Judgment** - Collaborative documentation will not work with every client in every situation.
Questions and Discussion

Please ask Questions! Here are some common ones...

• What if a client says “I don’t want to document during the session”?
• What if there is something the client says they do not want documented?
• How do you do CD during a telephone call?
• Does CD work with children? Certain ages?
• How do I use CD with parents/families?
• How do I use CD in Collateral Meetings?
• How do I do CD in groups?
• How do I do CD in the community, schools or in people’s homes?
• How do I document something I don’t want the client to see?
• What if a client is too cognitively impaired to participate in CD?