

The Who, What and How of Collaborative Documentation

with Maelisa Hall, Psy.D.

Workshop Goals

- Identify what is collaborative documentation
- Describe who is using it currently
- Identify the potential benefits and drawbacks
- Describe how to implement in private practice

Before we begin...

Take a moment to consider any biases.

Let go of any desperation or fear!

What is Collaborative Documentation?

Facts and changing ideas



What is collaborative documentation?

- Encouraging clients to be aware of the content of their records
- Writing notes with the client present
- Using client feedback directly in notes, assessments and treatment plans
- Allowing clients full access to online records for their own review

Who is Using Collaborative Documentation?

Surprising data



Who is using CD?

- Hospitals
- Mental health centers
- Non profit agencies
- Private practitioners
- Psychiatrists and therapists



Common Concerns About Collaborative Documentation?

Valid worries



*“My client will resent that we’re doing
paperwork.”*

*“It will take away time from clinical
treatment”*

Benefits of Collaborative Documentation?

Real life stories and legitimate data



Benefits

- Connects the clinical work and the paperwork (no longer “divorced” from one another)
- Supports a person-centered and client-driven approach
- Provides a clear and natural way to end the session

Benefits

- Addresses the changing culture in business
- Encouraging more transparency
- Aligns with the *meaning* of HIPAA



Benefits

- Improves time management
 - Take a moment to do the math on how much time you spend on paperwork
 - 20 clients x 10 minutes per note = 3 hours & 20 minutes weekly
 - Many clinicians report documentation takes up 30-50% of their work time
 - Leads to job dissatisfaction and burnout

**Could your clinical time be
spent elsewhere
(without sacrificing quality
and ethics?)**

Food for Thought

How Do Clients Respond?

It's not what you'd think



How Clients Respond

- One national study found:
 - 82% of clients found it either Very Helpful or Helpful
 - 79% reported feeling more involved compared with previous experience (either with same or different provider)
 - 77% reported they would prefer to continue the collaborative documentation process

How Clients Respond

- No show rates decreased
- Opened up dialogue with child clients who were previously resistant
- Allowed misunderstandings with clients to be more easily resolved

How Clients Respond

- Another study found that 4 out of 5 patients who had access to notes *read them regularly*
- Data showed that more open and honest communication may lead to decreased lawsuits



Collaborative documentation tends to *increase trust* because some clients feel that you secretly view them as "crazy."

How Clients Respond

- Especially helpful for those with substance abuse issues since allows them to review on their own time
- Significant client improvement when discussing sensitive issues
- Clients reported being more motivated to change and felt *more respected*

How Do Clinicians Respond?

Can they learn to love it...



How Clinicians Respond

- Felt like working *less*
- *Actually decreased volume* of documentation
- Quality of notes felt improved
- Felt more *connected* to documentation, saw increased value

Considerations Before You Begin

Start smarter, not harder



Considerations

- Office set up and type of documentation (paper, EHR, etc.)
- Which clients will fit best with this approach
 - Use clinical judgment for type of client
- May require a change of writing style

Considerations


- Are you prepared to dedicate 6-8 weeks to give it a fair shot?
- Work through your own attitude
 - How you view it is how your clients will view it
 - What are your own barriers or preconceived notions?

**My challenge to you:
What do you fear would
happen if your client saw
you write notes?**

Considerations

Consider coaching and accountability during your initial implementation.

>> You are not alone!



COLLABORATE

How to Implement Collaborative Documentation

Let's talk practicality



How To Implement

- Incorporate in *all* aspects of documentation
 - Treatment planning
 - Assessment
 - Notes

How To Implement

- Actual phrases to use:
 - *“You know that I write notes about our sessions and today I’d like to have you help with that”*
 - *“I’d like to get your feedback on our session today”*
 - *“Okay, let’s sum up what we’ve discussed today”*
 - *“Let’s stop here and review what we’ve talked about”*

How To Implement

- With children
 - *“When you see your mom, what will you tell her we did today?”*
 - *“Why don’t you tell your mom what we did today?”*
 - Give younger children tasks during the writing (stress ball, coloring, etc.)

How To Implement

- Use descriptive language of what was discussed
 - Focus on behaviors rather than clinical labels or judgments
 - Highlight client strengths
 - Use note writing prompts for easy discussion

How To Implement

- Write a partial note
 - Finish later for some clients
 - Increase the amount done over time

How To Implement

- Give yourself a **goal**
 - *How many of your clients will use this and by what timeframe?*
 - *What percentage of your note will be collaborative?*
- Takes about 6 weeks to get used to it

Questions?

Further Research/My Sources

- Bill Schmelter, PhD: Implementing Collaborative Documentation, Making it Happen!
 - http://www.integration.samhsa.gov/pbhci-learning-community/jun_2012_-_collaborative_documentation.pdf
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