

Worthwhile Concurrent Documentation

Compliant
Efficient
Person Centered

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PLAN for the Day

- Review Medical Necessity and Documentation Linkage and Challenges
 - Understanding Compliance & Medical Necessity
 - Service Process challenges that make useful/ compliant documentation hard
- Review Strategies for Intuitive, Useful, Compliant Documentation
 - Assessment
 - Treatment/ Service Planning
 - Progress Notes
- Understand the Value of Concurrent Documentation and Strategies for Incorporating it into Your Practice/ Agency.
 - Benefits
 - Strategies
 - Planning a pilot

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PLAN for the Day

Consider:

- What is Important for My Practice or My Agency?
- What can I start doing tomorrow?
- What will I need to find a way to work around?
- What changes would my agency or others need to make to accomplish an important change ? And how could I influence that?

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Worthwhile Documentation

Documentation Models Should Support:

- Compliance
- Efficiency
- Quality – Person Centered Services

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Problem

Most documentation does not reflect well on the Behavioral Health enterprise.

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Assumption ??

*“We do good work..
We just don’t document well”*

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What We Do – What We Write

How much of the Behavioral Health System's problem with compliance audits is due to documentation?

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OIG Audit of Medicare Part B Outpatient MH Services

- 41% billed inaccurately: wrong code, non-covered services, excessive billing
- 11% unqualified providers
- 65% poor documentation
- 23% medically unnecessary
- 22% receiving more services than necessary
- 8% not receiving enough services

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What We Do – What We Write

Common approaches to improving documentation compliance often include:

- Development of structured forms
- Implementation of 'compliant' EMRs (electronic medical records)
- Documentation training

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What We Do – What We Write

These approaches are critical but:

- Training often doesn't stick or actually translate to better compliance.
- Staff blame the forms and EMR (electronic medical records) for continued compliance failures.

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What We Do – What We Write

Separating the issues:

- Sometimes our documentation doesn't support medically necessary services.
 - This is a documentation support and training issue
- Sometimes our services, service structure or service processes make compliant documentation extremely difficult
 - This is a service integrity issue
 - In this case documentation support and training will produce, at best, marginal results.
 - Staff will blame the forms or the EMR

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It's Not All About Paperwork !

- Documentation should just be an accurate retrospective account of what we do
- If what we do makes sense and is billable then documenting it should not be a painful process
- We should not need to *Bend* our documentation to meet compliance standards
- Documentation should be intuitive and support our work

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Medical Necessity

“The type, intensity and duration of a service (Treatment, Rehabilitation, etc) as provided by an appropriately qualified practitioner and ordered in the current treatment plan is needed and appropriate to prevent worsening and/or produce improvement of symptoms and/or functioning level related to an approved diagnosis and assessed needs”

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Medical Necessity

- Appropriately Qualified Practitioner
- Clinically Appropriate Services
- At appropriate Intensity and Duration

As Prescribed in

- Individualized Tx Plan

Designed to

- To improve functioning and symptoms or prevent their worsening

Based on

- An Approved Diagnosis and Assessed Needs

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Documentation Linkage

Clinical View

Assessment Data:
Diagnoses - Assessed Needs - Service Recommendations
Service Plan Goals
Service Plan Objectives
Interventions and Services
Progress Notes

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Documentation Linkage

Auditor View

Progress Notes

TX. Plan Interventions, Services, Intensity
TX. Plan Objectives
TX. Plan Goals
Clinical Summary and Formulation
Assessment

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What We Do – What We Write

Common ‘Service Process’ challenges that make compliant documentation difficult

1. **Service Mix Inertia**
2. Program vs. Service Focus
3. Lack of Group Focus

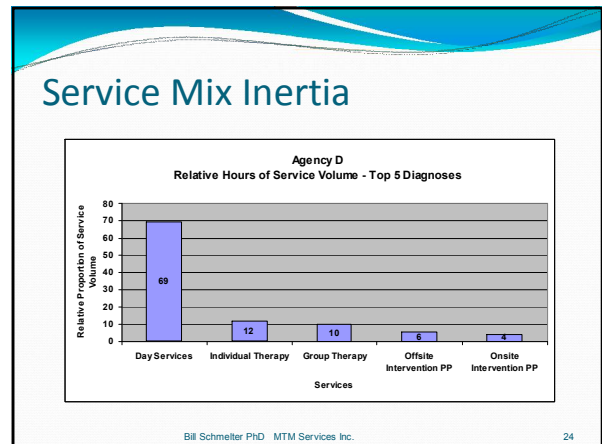
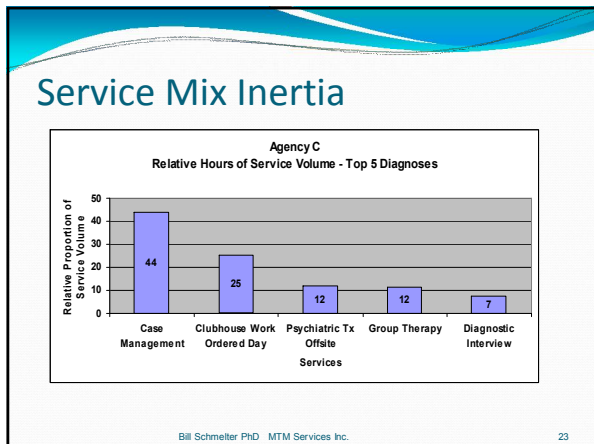
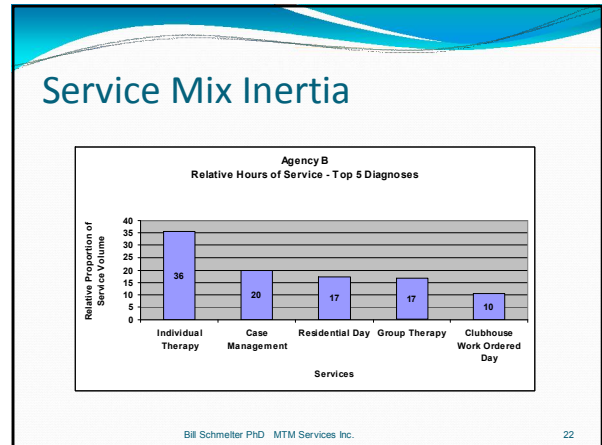
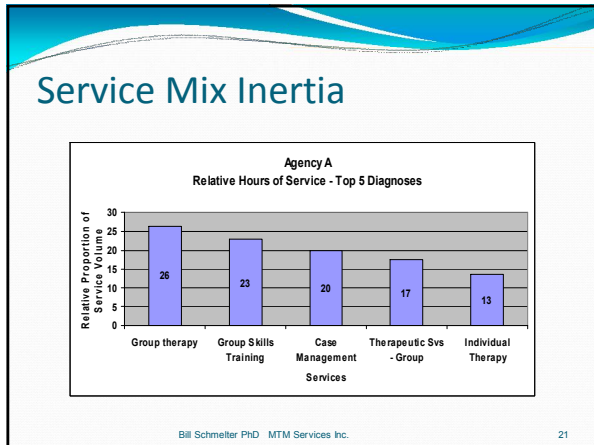
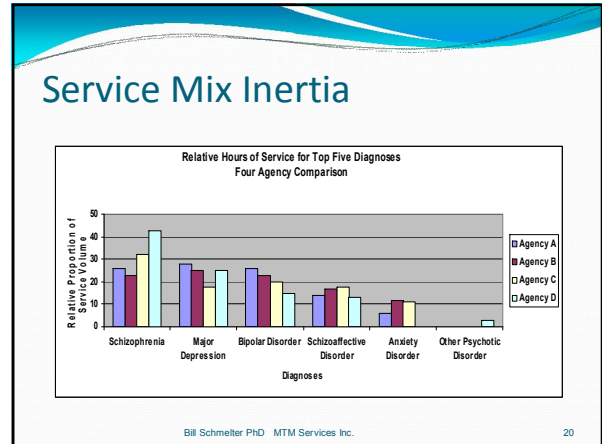
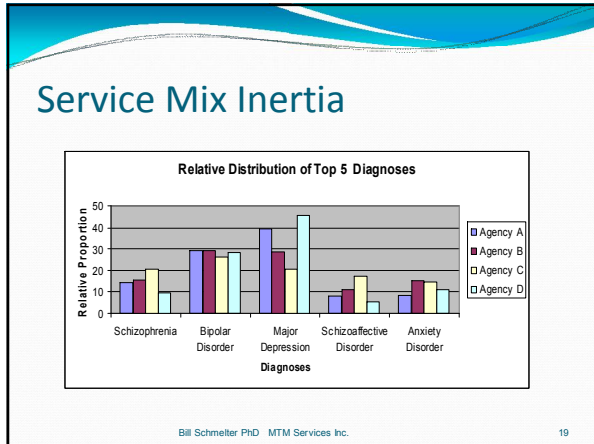
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Service Process Challenges

1. **Service Mix and Service Mix Inertia**

“What we got is what you get!”

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Service Mix Inertia

- What are the potential implications of this data for persons seeking treatment?
- What are the potential implications of this data for staff ability to produce compliant documentation?

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Service Mix Inertia

Population Service Needs

Assessment,
 Service Rec.
 Tx. Plan
 Process

Available Services

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Service Mix Inertia

Let's look at another provider

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Service Mix Inertia

Agency E
 Relative Proportion of Service Volume - All Diagnoses

Service	Relative Proportion (%)
Day Services	~85
Group Therapy	~15
Offsite Intervention MHP	~5
Onsite Intervention MHP	~5
Medication Maintenance	~5

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Service Mix Inertia

Agency E
 Relative Proportion of Service Volume - Major Depression

Service	Relative Proportion (%)
Day Services	~75
Group Psychotherapy	~15
Assessment	~5
Medication Maintenance	~5
Offsite Intervention MHP	~5

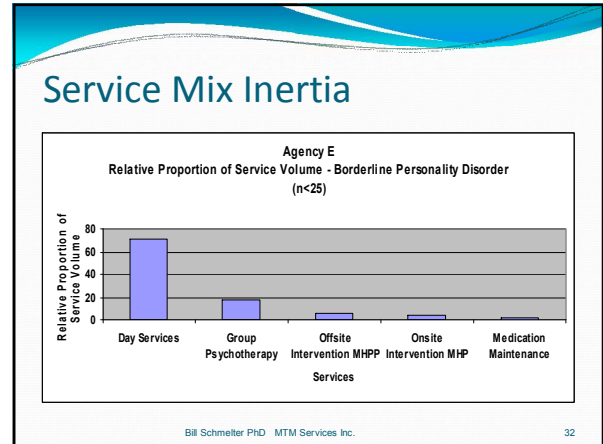
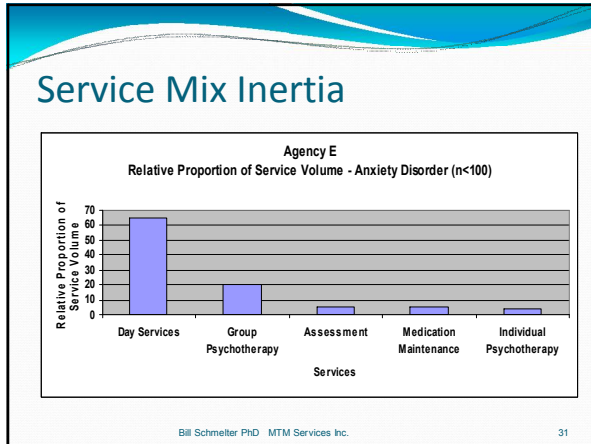
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Service Mix Inertia

Agency E
 Relative Proportion of Service Volume - Schizophrenia

Service	Relative Proportion (%)
Day Services	~80
Group Therapy	~15
Onsite Intervention MHP	~5
Offsite Intervention MHP	~5
Medication Maintenance	~5

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Service Mix Inertia

Key Points:

- Service Mix should ideally reflect the needs of the population being served
- Service Mix should trend toward increased use of Evidence Based / Best Practices
- A Service Mix that does not reflect the full array of client needs will place a strain on the ability to provide quality, compliant services and produce clinically intuitive, compliant documentation

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What We Do – What We Write

Common 'Service Process' challenges that make compliant documentation difficult

1. Service Mix Inertia
2. **Program vs. Service Focus**
3. Lack of Group Focus

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Service Process Challenges

2. **Program vs. Service Focus**

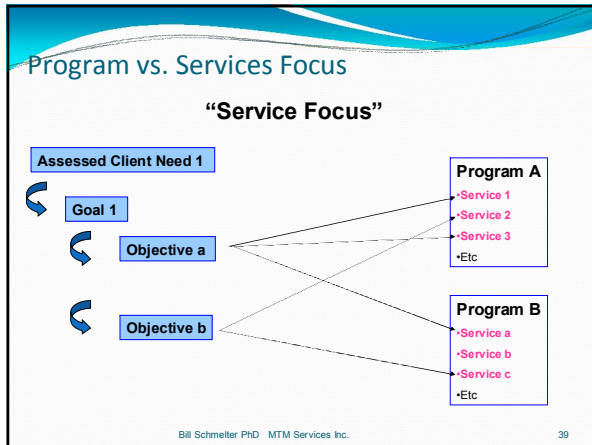
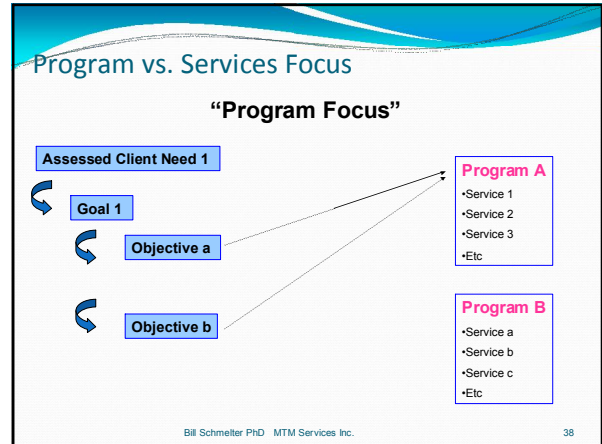
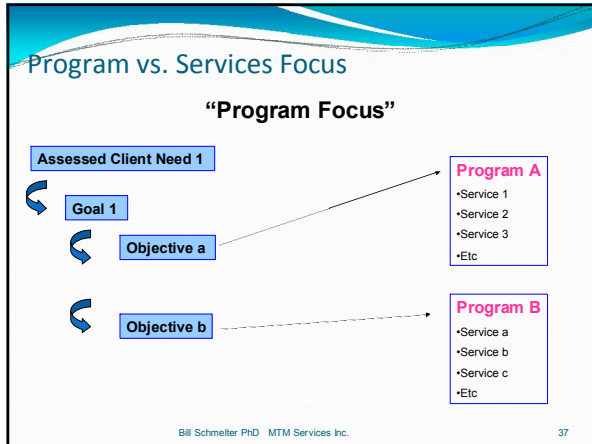
“One size fits all !”

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Program vs. Services Focus

- Ideally, based on a client's assessed needs, we develop goals and objectives and then prescribe what interventions and services would best help the client to achieve them.
- Organizations frequently organize into “Programs” that contain sets of services and interventions. This can be an efficient way to organize services.
- However, too frequently these programs form “silos” and take on a “life of their own” which can pose serious challenges for meeting medical necessity criteria

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- ### Programs vs. Services
- #### One Size Fits All
- Examples:
- Rehab/ Day programs with structured schedule of activities
 - Youth summer camps with structured schedule of activities
 - Case Management ‘Programs’ that provide homogeneous monitoring.
 - ‘Clinic’ considered a program
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- ### Programs vs. Services
- #### One Size Fits All
- How can a Program vs. Service orientation affect documentation compliance ?
1. Assessment Data often does not support and can contraindicate some services being provided in programs
 2. Treatment Plan Goals and Objectives need to become fitted to the program rather than assessed needs
 3. Interventions are often not known by the developer of the treatment plan and so the program is listed rather than specified services
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- ### Programs vs. Services
- #### One Size Fits All
- How can a Program vs. Service orientation affect documentation compliance ?
 - 4. Difficulty linking progress notes to treatment plan and assessed needs. (i.e. Makes documenting ‘golden thread’ difficult)
 - 5. Increases vulnerability for documenting what appear to be ‘habilitative’ services in progress notes
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What We Do – What We Write

Common 'Service Process' challenges that make compliant documentation difficult

1. Service Mix Inertia
2. Program vs. Service Focus
3. **Lack of Group Focus**

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Service Process Challenges

3. Group Focus

"What is Group Therapy"?

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Group Focus

Some Group Classifications:

- Evidenced based
- Curricula based
- Topic/ problem area focused
- Generic
- Generic, PRN, Support

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Group Focus

As you move from Evidence Based or Curricula Based to Generic and Especially PRN Support Groups the documentation challenge increases.

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Group Focus

How can lack of Group Focus affect documentation compliance?

1. Staff running 'generic' groups have great difficulty relating group discussions/ activities to individual needs, goals and objectives
2. Staff running 'generic' groups often admit that they do not really know the goals, objectives or interventions specified in group members' service plans.

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Group Focus

How can lack of Group Focus affect documentation compliance?

3. Progress notes become difficult to tie to specific goals and objectives often resulting in multiple goals and objectives being referenced (to cover everything) with no real linkage.
4. Support Groups are often prescribed in Service Plans "as needed" (PRN) or "from 1 to 4 times monthly" It is difficult to justify the medical necessity of such groups.

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Documentation Models

Documentation Models Should Support:

- Compliance
- Efficiency
- Quality – Person Centered Services

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Assessment

The Assessment Process *Flows*.....

Presenting Problem - Document what you know 'before collecting detailed assessment info' (e.g. basic demographics, why & how client came to you from client's and if applicable referral source's pt of view, who accompanied client, etc.)

Assessment Data - Collect complete assessment data as outlined in your forms. This information should come from all appropriate, available and reliable sources

Clinical Summary/Formulation - Document what you know at the end of assessment process. Diagnoses. Synopsis of presenting problem in the context of the client's personal goals and values, symptoms, skill and functional deficits, strengths, other salient assessment data and clinician's assessment of client motivation, potential obstacles, opportunities, etc.

Identified Needs and Service Recommendations - Prioritized needs and Service Recommendations organized by needs not services and programs.

50

Assessment

The customer of the Assessment is whoever is developing the Treatment Plan

They Need:

- Clearly identified and prioritized need areas that can be used to establish goals ("Clinical Formulation" or "Identified Areas of Need and Recommended Services")
- Symptoms, Behaviors, Skill and Functional Deficits stated as 'baselines' whenever possible in order to develop objectives.
- Client Strengths and Preferences that will be useful in developing the treatment plan Gs and Os.
- Support for the type and intensity of interventions and services being recommended.

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Assessment

Clinical Summary

- Is your best opportunity to "make sense" of the assessment data, and set the stage for meaningful goals, objectives and interventions, and.. **Support Medical Necessity**

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Assessment

Sample Assessment Section
Identified Needs and Service Recommendations

#	Identified Need	Recommended Services	A__D__R__

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Assessment

Examples of Identified Needs?

- Symptoms
- Behaviors
- Functional/ Skill Deficits
- Supports Deficits

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Service 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 (symptom or symptom cluster, one or a group of functional or skill deficits, a destructive behavior pattern, etc) and answers the question, "What do we (clinician and client) want the outcome of our work together to be, as we address this identified need?"

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Service Plan

Examples of goals:

- "Client states she wants to stop relapsing with alcohol and drugs so she can get her life back."
- "Client states he wants to stop getting into trouble in school and at home"
- "Client states he wants to feel normal so he can get a job and have friends"

For an involuntary/ non-engaged client.

- "Client will recognize the negative effects Substance Use is having on his life and voluntary participate in recovery services"

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Service Plan

How Many Goals ?

How Many Treatment/ Service Plans ?

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Service Plan

Objectives

Definition:

- Objectives are observable, measurable, changes in the client's behavior, functioning and/or symptoms (or in some cases changes in clinically relevant areas of the client's social/ support environment) that relate to achievement of the goal, and are expected to result from planned interventions.
- A client's Clinical Assessment should describe the measurable baseline levels of symptoms, functional/ skill deficits and behaviors that constitute the basis for the identified needs. Objectives are stated changes in these baselines.

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Service Plan

Examples of Objectives:

- "Client will reduce verbally aggressive outbursts in class from 3 or more times daily to once or less weekly."
- "Client will express an understanding that substance use is interfering with his life"
- "Client will report no substance use for 90 days"
- "Client score will improve from ____ to ____ on the XXX Depression Scale"
- "Client will begin to spontaneously express himself to others in a group of peers"

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Service Plan

Solution for the never changing Treatment Plan:

Break "Objectives" down into "Achievable Chunks"

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Service Plan

Interventions

Definition:
 An intervention is a clinical strategy or type of action that will be employed within a Service type (modality) and is expected to help achieve an Objective. Interventions briefly describe what approach, strategy and/or actions the Treatment Plan is prescribing for the practitioner.

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Service Plan

Examples of Interventions:

- “Teach the client to identify triggers for his anger”,
- “Teach client meal planning, shopping, and meal preparation skills”
- “Provide education on the physical, emotional and other effects/consequences of substance use”
- “Use CBT to help client change destructive irrational beliefs that lead to feelings of guilt”
- “DBT” (When an intervention strategy is very well articulated, has defined steps and outcomes, it may not be necessary to do more then indicate the type of intervention strategy.)

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Service Plan

Services

Definition:
 Services are the modalities or formats in which interventions are provided.

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Service Plan

Examples of services:

- Individual Therapy
- Group Therapy
- Case Management
- Community Support
- Psychiatric Rehabilitation program (Rehab Option Services)

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Sample

Goal, Objective, Interventions, Services, Frequency and Provider Type

Goal 2: (Based on Assessed Need # __) Client States he wants to feel less depressed so he can go back to work and have a social life again.

Objective a: Client's score will improve from ____ to ____ on the XXX depression inventory.

Interventions	Services	Frequency /duration	Provider type
Pharmacological treatment for depressive symptoms	Med Management	2X month for 60 days then 1X month	Psychiatrist
CBT to help client identify destructive irrational beliefs that result in severe feelings of guilt	Individual	1X week 1 hr	
Education and support for coping with depression	Group	1X week 1 hr	

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Progress Notes

- Linked directly to Goal(s) and Objective(s) in current Service Plan
- Describe the intervention provided (should be consistent with prescribed intervention(s) from Tx plan.
- Describe client's response to intervention
- Describe client's overall progress re the Goal/ objective being addressed
- Describe the plan for continuing work

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Progress Notes

If client brings up new issues/information decide if it is:

- Urgent:** if so address crisis and document. If crises become chronic may need to review Tx Plan approaches/ level of care
- New, clinically relevant information.** If so do an assessment update and determine if Tx Plan needs revision
- Mini Crisis/ Conversation point** – if so bring discussion back to treatment plan. Do not get caught up ‘meandering with the client’.

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Person Centered Services

What does this mean?

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Person Centered Services

Person Centered Services

Documentation Linkage, “The Golden Thread” , is not just about compliance....

The “Golden Thread” supports the process of provider and client both remaining focused on needs, strengths, goals, objectives, and progress.

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Person Centered Services

“Ensuring that individuals and families are at the center of the process and directing their own plans and care should be an essential component of transformation in health care delivery”

Adams and Grieder. “Treatment Planning for Person Centered Care (2005)

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Person Centered Services

Why adopt a Person Centered approach?

- Politically Correct?
- More Respectful?
- Feels Right?

No!

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Person Centered Services

Why Adopt a Person Centered Approach?

- Improve Engagement !
- Reinforce Ongoing Motivation and Hope !
- **Improve Outcomes !**

YES !

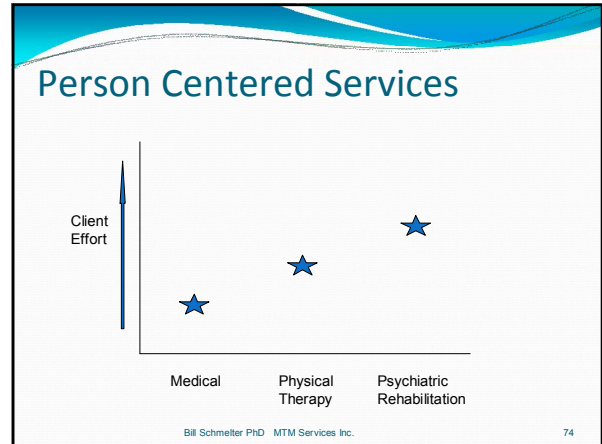
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Person Centered Services

Put the following in order indicating the most engagement (effort/motivation) on the part of the client.

- Physical therapy
- Psychiatric Rehabilitation
- Medical treatment (medication, major surgery, etc)

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Person Centered Services

- Difficult to imagine someone engaging in this level of effort unless they are invested in the outcome, understand and believe in the process for achieving the outcomes, and experience hope and optimism.

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Person Centered Services

Where in your Organization Does it Happen?

- The Person Centered approach should be consistently integrated in our Behavioral Health Core Service Processes and *reflected* in their Documentation

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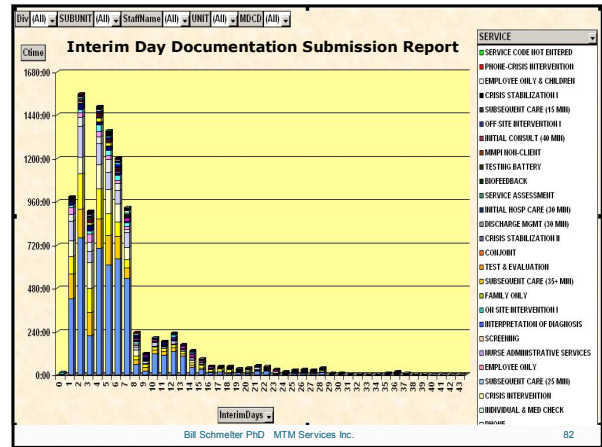
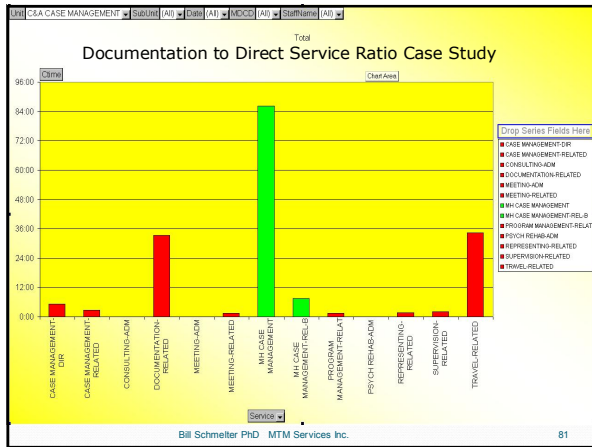
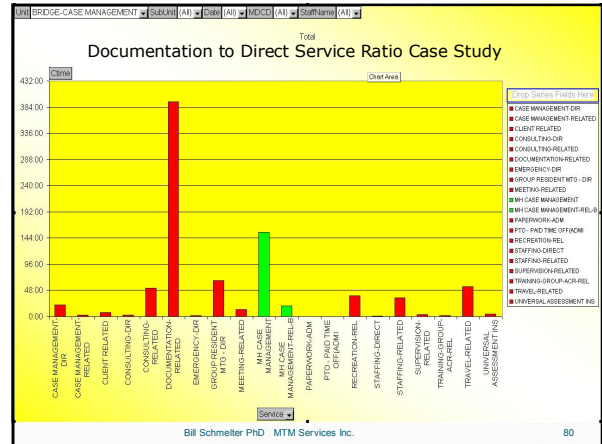
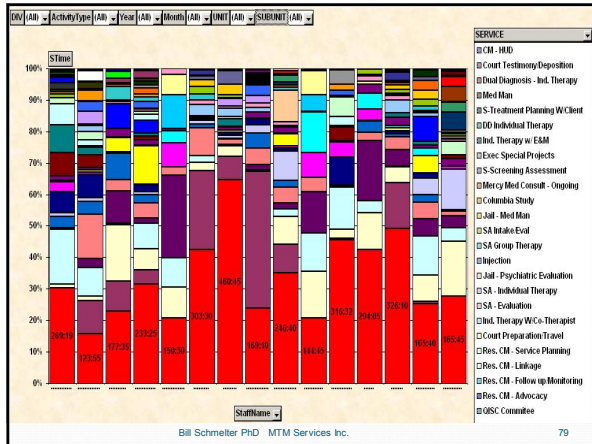


Concurrent Documentation

Benefits:

- Creates Staff Capacity
- Improves staff quality of work life
- Supports person centered services
- Supports compliance

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Activity Type	Client Contact Time (min.)	Approx. Doc./Note taking time with Client (min.)	Total Post Session Doc. Time (min.)	Total Doc. Time (min.)	Total Activity Time (min.)
Assessment - A	101	10	60	70	171
Progress Note - PN	60	2	30	32	92
Treatment Plan - TP	60	15	45	60	120
Treatment Plan Update-TPU	60	15	30	45	105
Outcomes - O	30	10	45	55	85
Average	62.2	10.4	42	52.4	114.6

Avg. Documentation to Direct Service Ratio: 0.84

Activity Type	Documentation Time	Direct Service Time
Assessment - A	0.08	1.00
Progress Note - PN	0.03	0.17
Treatment Plan - TP	0.13	0.83
Treatment Plan Update-TPU	0.06	1.00
Outcomes - O	0.08	1.25
Average	0.08	0.85

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Effect of Direct Service to Documentation Ratio on Performance

Using a 40 hr week and a 100 hour per month direct service standard:

Dir Hrs	Doc Hrs	Max Dir hrs/wk	Max Dir hrs/mo	Time for all else (hrs /mo) (if meet standard)
1	2	13.3	53.2 (83.2% of Standard)	0
1	1	20	80 (80 % of Standard)	0
2	1	26.6	106.4 (106.4% of Standard)	10-hrs (3 weeks/yr)
3	1	30	120 (120% of Standard)	26.8-hrs (8 weeks/yr)

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Two Major Causes of High Documentation to Direct Service Ratio

- Carrying Inactive Cases
- Post Service Documentation Model

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Remedies for High Documentation to Direct Service Ratio

- Close Inactive Cases (and Inactive 'Active' cases)
- Concurrent Documentation Model

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Post Service Documentation

- Developed during the Grant Funding Era (cost based contracts)
- Doesn't work under fee for service and/or capitated models
- Increases documentation to direct service ratio
- Greater risk of non compliance

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Concurrent Documentation

Appropriate for use:

- During Diagnostic Assessments, Service Planning, Diagnostic Assessment Updates and Service Plan Updates
- At the end of service for Progress Notes in clinic or in community

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Concurrent Documentation

Most Common Reasons for Resistance

- It can't happen here! (Terminal Uniqueness)
- It will interfere with the therapist/ client relationship

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Concurrent Documentation

The 7% Percent Factor

- There are situations where concurrent documentation is not appropriate
- 93% of the time concurrent documentation is appropriate, positive and helpful.
- Failures to implement are often due to a focus on the 7%
- Use clinical judgment - but "try it - you'll like it" and so will the majority of your clients.

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Concurrent Documentation

Organization that have adopted concurrent documentation

- Southlake Center for Mental Health**
Merrillville, IN
- North Suffolk Mental Health**
Chelsea, MA
- MHC of Greater Manchester**
Manchester, NH
- DuPage County Health Department - Mental Health Services**
Wheaton, IL

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Mid Western Colorado: 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.

92

Mid Western Colorado: Benefits of Concurrent Documentation

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.

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Mid Western Colorado: Benefits of Concurrent Documentation

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.

94

Mid Western Colorado: Benefits of Concurrent Documentation

To MHC Staff:

- 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.

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Metropolitan’s Concurrent Documentation Pilot Outcomes

Metropolitan provided a pre-post evaluation of a 6 week concurrent documentation pilot. The results were:

- Pilot therapists rate quality of the working alliance with clients equal to therapists in the control group.
- Pilot client/therapist pairs show almost identical levels of agreement with client/therapist control group pairs regarding working alliance
- On average pilot therapists spent 9 fewer post session hours on paperwork per week than control group therapists.

96

MHC of Greater Manchester Concurrent Documentation Case Study

- **Client Satisfaction Results:**
- 927 Clients Responded
 - 83.9% felt the practice was helpful
 - 13.7% found it neutral
 - 2.3% disagree that it is helpful

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CONCURRENT DOCUMENTATION CASE STUDY NOTES
By: John Kern, MD, Medical Director
Southlake Mental Health Center

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.

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CONCURRENT DOCUMENTATION CASE STUDY NOTES
By: John Kern, MD, Medical Director
Southlake Mental Health Center

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

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CONCURRENT DOCUMENTATION CASE STUDY NOTES
By: John Kern, MD, Medical Director
Southlake Mental Health Center

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.

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CONCURRENT DOCUMENTATION CASE STUDY NOTES
By: John Kern, MD, Medical Director
Southlake Mental Health Center

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.

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CONCURRENT DOCUMENTATION CASE STUDY NOTES
By: John Kern, MD, Medical Director
Southlake Mental Health Center

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.

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Some Staff Competency Challenges to Conversion to Concurrent Documentation

- Computer hardware and software skills (EMR)
- Ability of staff to provide a more focused/objective information gathering/recording model/clinical formulation
- Provide training to provide permission to write less words and identify which words need to be written to support Medical Necessity documentation linkages

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Concurrent Documentation - Logistics



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Transition from Post Documentation to Concurrent Documentation Model

- “Do As Much As You Can” approach
 - Client’s response to the intervention section of the progress note
 - Add Goal and Objective addressed today
 - Add interventions provided
 - Add mental status/functioning levels
 - Complete progress note in session

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Mid-Western Colorado: Concurrent Documentation Guidelines

Staff 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

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Concurrent Documentation: Where to Start?

- Easiest Place to Start is with Progress Notes

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Mid Western Colorado: Concurrent Documentation Guidelines

Transitioning to CD In the session

- 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 we write it down on paper or it’s done directly on the computer ECR.

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Mid Western Colorado: Concurrent Documentation Guidelines

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.

109

Mid Western Colorado: Sample Script

A Program Supervisor in Mid Western Colorado 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.”

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Mid Western Colorado: Concurrent Documentation Guidelines

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.”*

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Mid Western Colorado: Script Guidelines

Your script should include the following items:

- Explain that ‘concurrent documentation’ 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.
- Frame it more as an “invitation” to their participation in treatment rather than a “requirement.”
- 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.
- Enumerate the benefits to their participation in this way (See benefits of Concurrent Documentation – To the Consumer/Family).

112

Mid Western Colorado: Concurrent Documentation Guidelines

- 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 written note or computer as they wrap up. 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.

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Mid Western Colorado: Concurrent Documentation Guidelines

Examples:

- 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.

114

Mid-Western Colorado: Concurrent Documentation Guidelines

Examples:

- 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.

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Concurrent Documentation Scenarios

- Individual Modality in Clinic Office Setting (EMR and Paper)
- Community Setting (EMR and Paper)
- Group Modality (EMR and Paper)
- School Based Services (EMR and Paper)
- Day Program

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Concurrent Documentation

- Implementing a Pilot
 - Select Pilot “Volunteers”
 - Collect Baseline Documentation Time Data
 - Train
 - Pilot Process
 - Collect New Documentation Time Data as well as qualitative data from Pilot Staff
 - Implement Agencywide

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- **Show** tool for Developing baseline and Monitoring Progress

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