The Clinical Benefits of Collaborative Documentation
And Other Important Considerations

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Collaborative Documentation is a clinical strategy in which the clinician reviews the session with the client as they document this in the record (e.g. goals and objectives addressed, interventions provided, progress in meeting goals and objectives, clients response to the sessions today, and the plan/recommendations for things the client and if applicable the clinician will do prior to the next session). It replaces the clinical "wrap-up", using a written medium to reinforce the above important aspects of the session/interaction. Collaborative Documentation does not extend the duration of treatment/interaction sessions!

The client must be engaged in the documentation process by, at minimum, having the ability to view what is being written as well as the opportunity to express their perspectives and disagreements if applicable.

Collaborative Documentation is not Concurrent Documentation. It is not documenting throughout a therapeutic interaction just to get the note completed efficiently.

Collaborative Documentation provides a number of important Clinical Benefits:

1. **Improved Care Coordination and Risk Management (Real Time Documentation Access by Other Clinical Team Members):** The implementation of Electronic Health Records (EHRs) allows members of the treatment team (Therapists, Case Managers, Psychiatrists, etc.) to have easy access to documentation of previous encounters with other team members. However, this can only happen if the documentation is present in the chart. Documentation timeliness standards of 24, 48, or 72 hours (with typically 20-30% of documentation not meeting any of those standards) are no longer acceptable. If a prescriber sees a client today who was seen the previous day by a case manager or therapist, the prescriber should have access to the description of that encounter. This is good care coordination and also manages the potential risks associated with lack of such communication. Collaborative Documentation makes documentation timeliness standards a moot issue.

2. **Clinical Engagement:** There is published evidence that Collaborative Documentation significantly reduces no-shows and cancellations and significantly improves medication adherence (Appendix 1- abstract of article published in the January 2013 Issue of Psychiatric Services). We also have significant evidence that clients feel more involved in treatment as a

result of Collaborative Documentation (Appendix 2 - survey results from over 17,000 clients and families). Further support for improved engagement is reflected in the attached (appendix 3) abstract of the Robert Woods Johnson Foundation – "Open Notes Project published in the October issue of the Annuals of Internal Medicine.

In addition, most clients have just a theoretical knowledge that there is a record of their interactions with us. However, when they actually see and can participate in the record of their treatment they become much more likely to clarify information, and express disagreements with recommendations and or perceptions.

3. **Improved Focus on Treatment Plan and Outcomes:** Most clients do not know their specific treatment plan Goals and Objectives. This is because during sessions clinicians do not regularly discuss these with clients and generally do not review progress in relation to specific goals and objectives. When they document the sessions after the client leaves they are they required to relate the intervention to current goals and objectives even though this was not specifically discussed during the session. Collaborative documentation forces the reference to the goals and objectives being addressed and encourages stating progress in relation to those goals and objectives, resulting in improved recall.

4. **Improved Clinical Accountability (Clients and Clinicians):** Since documentation will be completed at the end of sessions clinicians are held accountable to actually provide focused interventions, review progress against goals and objectives, and make recommendations, as opposed to sometimes having a less focused conversations and then later crafting a note to meet regulations and standards. Many clinicians have reported that treatment is progressing a lot more quickly due to Collaborative Documentation. Also since treatment recommendations recorded in the "plan" section of progress notes becomes a written agreement to apply those recommendations, clients are more likely to question the benefits of a recommendation or suggest alternative recommendations when they know they are being documented. This inherently engages the client as participant in treatment

5. **Increases Clinical Capacity:** While the time savings resulting from implementing Collaborative Documentation may viewed as reflecting that it is "just an efficiency tool to increase productivity", this really translates to increased Clinical Capacity. This capacity is needed to better treat all clients by supporting rapid access to service, the ability to address crises in a timelier manner, and the ability to accommodate the reduction in no shows and cancellations that result from these clinical improvements. Clinical capacity should not be wasted by spending hours sitting offices completing documentation.

Other Important Benefits and Considerations:

1. **Improved Compliance:**
    a. **Treatment Plans improve!** As staff need to focus with the client on Goals and Objectives during Collaborative Documentation (see item 3 above) they come to realize that they need more useful Goals and Objectives. These need to actually make sense to the client and be measurable or observable outcomes that help clients and clinicians know if their work together is helping.

b. **Documentation of interventions improves!** Since clinicians write their interventions with the client they will be stated in terms of what was discussed, observations made, etc. Intervention statements such as, "Helped client process their feelings" or "Employed empathic listening" which do not add value to the record will disappear. More importantly failure to indicate any intervention at all but just reporting things the client said (an all too common occurrence and major threat to compliance) is much less likely to occur.
c. **Accuracy improves!** Progress notes written after 24 or 48 hours become "Impressionist "Paintings" of the session, beyond that – well – we're in Picasso's Cubism territory. Completing documentation at the time of service insures accuracy, and clients have the ability to clarify or disagree with what they perceive as incorrect interpretations of things they said. Clients also often ask for information that they found important during the session to be added.

2. Is Informed Consent to Share/Release Clinical Information Really Informed?

We have clients sign informed consent to release clinical information agreements as a condition to participate in treatment. However, clients do not generally understand the nature or content of what is being shared. When clients request to review their charts they are often upset at the conclusions, observations, and hypotheses that are recorded in "their" chart. This is becoming an even more important issue as primary care physicians are increasingly being integrated into treatment teams. Recently a client was quite upset with their therapist when their primary care physician discussed the client's substance use - which the client had not reported to them but only to the therapist. In a collaborative documentation model the therapist would explain that the information regarding substance use must be in the record because it is important information to help their physician and other team members treat them safely.

The most ethical way to handle informed consent is to allow clients to know what is being recorded and to have the opportunity to include their perspective and/or disagreements.

Appendix 1

The Impact of Person Centered Planning and Collaborative Documentation on Treatment Adherence

PSYCHIATRIC SERVICES

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Abstract

Objective: Person-centered planning has emerged as a recovery oriented practice by tailoring service planning to personal life goals. This study examines the impact of person-centered planning combined with collaborative documentation on service engagement and medication adherence within community mental health centers. **Methods:** Five community mental health centers were randomized to training in person-centered planning and collaborative documentation and five were randomized to treatment as usual. Medication adherence and service engagement were measured over an 11 month period. Models examined changes in medication adherence and service engagement over time among clients in control versus experimental conditions. **Results:** The experimental condition showed significant increase in medication adherence (B=0.022, p=<0.01) while the control condition showed no significant change (B=0.004, p=0.25). The experimental condition also had reduced appointment no-shows (OR=.74, p=.0012). **Conclusion:** Overall, the study found that person-centered planning and collaborative documentation was associated with greater engagement in services and higher rates of adherence.

Appendix 2

Results of Client and Family Response Surveys

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?	Percentages Total	Total %
1 Very Unhelpful	1035	4%
2 Not helpful	289	1%
3 Neither helpful nor not helpful	2086	9%
4 Helpful	7116	31%
5 Very Helpful	11930	52%
NA No Answer/No Opinion	566	2%
Total/Approval %:	**23,022**	**94%**

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)?	Total	Total %
1 Very Uninvolved	537	2%
2 Not involved	217	1%
3 About the same	2987	14%
4 Involved	6279	28%
5 Very Involved	11436	52%
NA No Answer/No Opinion	629	3%
Total/Approval %:	**22,085**	**96%**

3. On a scale of 1 to 5, how well do you think your provider did in introducing and using this new system?	Total	Total %
1 Very Poorly	98	0%
2 Poorly	53	0%
3 Average	925	4%
4 Good	5382	24%
5 Very Good	15132	69%
NA No Answer/No Opinion	423	2%
Total/Approval %:	**22,013**	**99%**

4. On a scale of 1 to 3, in the future, would you want your provider to continue to review your note with you?	Total	Total %
1 No	1149	5%
2 Unsure	2514	12%
3 Yes	16422	77%
NA No Answer/No Opinion	1132	5%
	0	0%
	0	0%
Total/Approval %:	**21,216**	**94%**

Appendix 3

Annals of Internal Medicine | ORIGINAL RESEARCH

Inviting Patients to Read Their Doctors' Notes: A Quasi-experimental Study and a Look Ahead

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Background: Little information exists about what primary care physicians (PCPs) and patients experience if patients are invited to read their doctors' office notes.

Objective: To evaluate the effect on doctors and patients of facilitating patient access to visit notes over secure Internet portals.

Design: Quasi-experimental trial of PCPs and patient volunteers in a year-long program that provided patients with electronic links to their doctors' notes.

Setting: Primary care practices at Beth Israel Deaconess Medical Center (BIDMC) in Massachusetts, Geisinger Health System (GHS) in Pennsylvania, and Harborview Medical Center (HMC) in Washington.

Participants: 105 PCPs and 13 564 of their patients who had at least 1 completed note available during the intervention period.

Measurements: Portal use and electronic messaging by patients and surveys focusing on participants' perceptions of behaviors, benefits, and negative consequences.

Results: 11 797 of 13 564 patients with visit notes available opened at least 1 note (84% at BIDMC, 92% at GHS, and 47% at HMC). Of 5391 patients who opened at least 1 note and completed a postintervention survey, 77% to 87% across the 3 sites reported that open notes helped them feel more in control of their care; 60% to 78% of those taking medications reported increased medication adherence; 26% to 36% had privacy concerns; 1% to 8% reported that the notes caused confusion, worry, or offense; and 20% to 42% reported sharing notes with others. The volume of electronic messages from patients did not change. After the intervention, few doctors reported longer visits (0% to 5%) or more time addressing patients' questions outside of visits (0% to 8%), with practice size having little effect; 3% to 36% of doctors reported changing documentation content; and 0% to 21% reported taking more time writing notes. Looking ahead, 59% to 62% of patients believed that they should be able to add comments to a doctor's note. One out of 3 patients believed that they should be able to approve the notes' contents, but 85% to 96% of doctors did not agree. At the end of the experimental period, 99% of patients wanted open notes to continue and no doctor elected to stop.

Limitations: Only 3 geographic areas were represented, and most participants were experienced in using portals. Doctors volunteering to participate and patients using portals and completing surveys may tend to offer favorable feedback, and the response rate of the patient surveys (41%) may further limit generalizability.

Conclusion: Patients accessed visit notes frequently, a large majority reported clinically relevant benefits and minimal concerns, and virtually all patients wanted the practice to continue. With doctors experiencing no more than a modest effect on their work lives, open notes seem worthy of widespread adoption.

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