Concurrent/Collaborative Documentation

Hi Care Counselors! Here is my (rather informal) handout about collaborative documentation. References at the bottom.

Lemmie know if you need help or want to chat about any of this.

Cheers!
Erin A

How do I present the service?
"During the intake, you will see me at my computer typing basically the whole time. This is because I'm trying to learn as much about you as I can in a short time. Once we get to a regular therapy session, you will see me on my computer at the beginning of session, where I will be writing about your levels of symptoms and how you were feeling that week. Then you'll see me take out my computer at the end of session, about quarter to the hour, where we will summarize the session together and write down the homework. Once in a while you may see me grab the computer in the middle of session if something feels important and I want to remember it. If you are ever curious about what I'm writing, feel free to ask me.

I like to do a collaborative note for a couple reasons: it's weird to see your therapist writing stuff down. Many people might think, 'What is she writing? Is she writing that I'm crazy?' I don't want your medical record to be a mystery or something that separates us. I want it to be out in the open and something that connects us. Does that sound fair?

Also, sometimes my clients have really cool insights that I didn't think of, or they remember things that I have forgotten. When I have you summarize the session, it's also giving me a feel for what you're experiencing and what you're getting out of the experience. It helps me understand how the therapy is going for you."

For the therapist:
Collaborative documentation can be:

1. Assessment
    a. Am I effectively attuned?
    b. How is client's cognitive functioning and/or emotional awareness?
    c. What cognitive distortions is the client experiencing?
    d. How does the client perceive the relationship?
2. A check for understanding
3. A way to consolidate learning
4. A way to show the client we are indeed doing something; something is happening; we are working! My client who does clicker training with dogs calls it a "mark."
5. A way to enhance the alliance; we are on the same team!
6. A way to enhance confidence in the treatment

7. A way to have a professional boundary; I care about you, but I'm not your friend. You can tell, because I am charting. ;) I would not say that out loud. But I do think the computer can have that effect.
8. A way to have more time and energy at work; a way to avoid burn out! Do therapy, go home!
9. A way to have time to eat lunch with your colleagues and form a greater sense of team.

Advantages of having your computer out

1. Easy to toggle back to the last session using the history button
    a. To continue the golden thread
    b. To give continuity to the larger conversation of the therapy
    c. To hold clients accountable to their homework
    d. To keep focus on the treatment goals. I will often start session by saying,
        i. Any safety issues?
        ii. How would you rate your dep/anx from 0 to 10?
        iii. How was the homework? Or What got in the way of the homework?
        iv. We have a goal about skills for anxiety, a goal about processing grief about mom, and a goal about being assertive. Where would you like to start today? Or do you have another topic that feels important?
2. Easy to look quickly at the schedule and remind them of their next appointment.

What if a client is resistant to the therapist having the computer out?

1. Offer to read the whole note aloud, or to let them read it.
2. Say, "let's try it out for a couple weeks and see if we get used to it."
3. Offer to do collaborative notes on paper for two weeks and then try switching over.

What if a client is resistant to summarizing the session?
Sometimes anxious clients feel put on the spot. Or perfectionistic clients want to make the perfect summary.

1. Try other ways of asking:
    a. What's your biggest take away from our session?
    b. What felt important from today?
    c. What are your impressions about today?
    d. Allow clients to write things down, during the session or in between sessions.
    e. If you have a teen who needs irreverence: what is the dumbest thing I said today? What was the *least* dumb thing I said today?
2. Start typing and start sharing with them what you write. Then check in with them, "I'm writing that we processed some feelings and thoughts about your dad today. I'm writing that I validated your feelings and encouraged you to be patient with yourself. Does that sound right to you? Is there anything I forgot?"

References

Matthews, E. B. (2019). Computer use in mental health treatment: Understanding collaborative documentation and its effect on the therapeutic alliance. Psychotherapy. Advance online publication. https://doi.org/10.1037/pst0000254

Abstract: Amid increases in electronic health record adoption, many psychotherapists are concerned that in-session computing may harm the client-provider relationship, also known as the therapeutic alliance. The emerging practice of collaborative documentation (CD) is one strategy designed to prevent this outcome. Little empirical work has examined the effects of in-session computing generally or CD specifically within the psychotherapeutic context. This study explores how CD is being implemented in psychotherapy and examines how both the frequency of computing and the use of CD affects the therapeutic alliance. Psychotherapists in this study engaged in an average of 42 (SD = 38.5) computing episodes. CD was present in 39% of sessions (N = 21). Regression models found that among providers, increases in computing frequency predicted decreases in alliance (ß = -.18, p < .05). Conversely, among clients, the use of CD improved alliance (ß = .43, p < .01). Findings suggest that psychotherapists use computers often, but parties view the effect of electronic health records differently. Reconciling this disparity and continuing to develop effective technology-based best practices is imperative. (PsycINFO Database Record (c) 2019 APA, all rights reserved).

Electronic health records in social work practice

Matthews, Elizabeth B. (author); Angell, Beth (chair); Akincigil, Ayse (internal member); Greenfield, Emily (internal member); Stanhope, Victoria (outside member); Rutgers University; School of Graduate Studies

Date Created2018

Other Date2018-10 (degree)

SubjectSocial Work, Medical records--Data processing

Extent1 online resource (205 pages) : illustrations

Abstract: DescriptionThe use of electronic health records (EHRs) is becoming normative in behavioral health treatment. Despite this, little is known about how to use these systems in a way that supports best practices, including the provision of person-centered care (PCC). PCC refers to a clinical approach that emphasizes individualized, collaborative care and a strong working alliance (WA) between clients and providers. Collaborative documentation (CD), the process of completing progress notes jointly with clients, has been promoted as a model of in-session computer use that can support this practice, but has been controversial among behavioral health providers. Advancement of CD has been hindered by the lack of empirical studies examining its effectiveness. This quantitative study examines how behavioral health providers use EHRs within a therapeutic context, and tests the impact CD has on PCC.

This exploratory study drew from a sample of 53 therapy sessions where EHRs were used. Data sources included a video recording of each session, and post-visit surveys completed by both clients and providers. Video data was coded for computing frequency, and the use of CD with clients. Surveys measured client and provider ratings of person-centered care and collaborative documentation. Univariate statistics describe the extent of computer use during sessions. Paired sample t-tests explored differences in client and provider perceptions of PCC and CD. Finally, the association between the amount of computer use, CD and PCC was tested using OLS regression, adjusting for nesting with a random effect at the provider level. The first model examined the direct effects of CD on PCC, and a second model explored the moderating effects of CD on the relationship between total computing and PCC.

Results indicate that behavioral health providers spend about 33% of visit time using the computer, but clients and providers view the impact of these behaviors on PCC differently. Among providers, total computing had a direct, negative association with working alliance (WA), an essential component of PCC. Conversely, clients generally had more favorable attitudes towards the quality of their WA with their providers and the ways in which they used computers in sessions. Furthermore, among clients, CD predicted higher ratings of PCC and WA, regardless of how often computers were used.

These findings suggest that, while providers felt pessimistically about the impact of EHRs on PCC, clients did not share this experience, particularly when CD was deployed. To this end, results indicate that requisite skills surrounding collaborative use of technology are critical to

harnessing the benefits of this technology. This underscores the need to continue developing and disseminating effective strategies for EHR use.

NotePh.D.

NoteIncludes bibliographical references

Noteby Elizabeth B. Matthews

Genretheses

Persistent URLhttps://doi.org/doi:10.7282/t3-4zv3-sj22

Languageeng

CollectionSchool of Graduate Studies Electronic Theses and Dissertations

Organization Name Rutgers, The State University of New Jersey

Bachelor, A., Laverdière, O., Gamache, D., & Bordeleau, V. (2007). Clients' collaboration in therapy: Self-perceptions and relationships with client psychological functioning, interpersonal relations, and motivation. Psychotherapy: Theory, Research, Practice, Training, 44(2), 175–192. https://doi.org/10.1037/0033-3204.44.2.175

Delbanco, T., Walker, J., Bell, S. K., Darer, J. D., Elmore, J. G., Farag, N., … others. (2012). Inviting patients to read their doctors' notes: a quasi-experimental study and a look ahead. Annals of Internal Medicine, 157(7), 461–470.

Lenert, L., Dunlea, R., Del Fiol, G., & Hall, L. K. (2014). A Model to Support Shared Decision Making in Electronic Health Records Systems. Medical Decision Making, 34(8), 987– 995. https://doi.org/10.1177/0272989X14550102

Midwestern Colorado Center for Mental Health. (n.d.). Concurrent documentation pilot project training. Midwestern Colorado Center for Mental Health.

MTM Services. (2012). Implementing collaborative documentation. Powerpoint slides by Bill Schmelter. Retrieved from http://www.integration.samhsa.gov/pbhci-learningcommunity/june_2012_-_collaborative_documentation.pdf

Schmelter, B. (2010). Compliance, medical necessity, and collaborative concurrent documentation. Retrieved November 16, 2014, from https://www.omh.ny.gov/omhweb/clinic_restructuring/training_materials/medical_necess ity.pdf
Schmelter, B. (2012, June 22). Implementing collaborative documentation (SAMHSA). MTM Services & SAMHSA.

Stanhope, V., Ingoglia, C., Schmelter, B., & Marcus, S. C. (2013). Impact of person-centered planning and collaborative documentation on treatment adherence. Psychiatric Services, 64(1), 76–79.

Wiarda, N. R., McMinn, M. R., Peterson, M. A., & Gregor, J. A. (2014). Use of technology for note taking and therapeutic alliance. Psychotherapy, 51(3), 443–446. https://doi.org/10.1037/a0035075

Craig, S. L., & Calleja Lorenzo, M. V. (2014) Can information and communication technologies support patient engagement? A review of opportunities and challenges in health social work. *Social Work in Health Care*, *53*(9), 845–864.

https://scholarworks.sfasu.edu/jhstrp/vol3/iss1/2/

Maniss, Suzanne Ph.D., LCDC, NCC and Pruit, Amanda G. LPC (2018) "Collaborative Documentation for Behavioral Healthcare Providers: An Emerging Practice," *Journal of Human Services: Training, Research, and Practice*: Vol. 3 : Iss. 1 , Article 2.

Available at: https://scholarworks.sfasu.edu/jhstrp/vol3/iss1/2

“According to Grantham (2010), providers at a large mental health center serving approximately 10,000 individuals from six counties in multiple locations decreased documentation time from an average of 11 minutes per encounter to 3 minutes per encounter by utilizing CD in an EHR system. To illustrate, if providers at the center saw 30 clients per week and used CD with an EHR system, they would save more than five hours of documentation time per week. “