Concurrent Documentation: A Case Study

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Editor's note: This article provides a summary of the basic accountable care principles the author incorporates in his book entitled, **How to Deliver Accountable Care!,** available through the National Council of Community Behavioral Healthcare in Rockville, MD. Accountability-Based concurrent documentation models have proven to be a very effective quality improvement and compliance strategy as CBHOs respond to a combination of stagnant/declining funding and increased compliance and performance requirements. (Please refer to About the Author section at the end of the article).

The ever changing funding and compliance challenges for Community Behavioral Healthcare Organizations (CBHO) have required Management Teams to reconsider the basic tenets of historical direct service delivery models.

Due to enhanced external accountability requirements, CBHOs have already in many cases addressed organizational change needs, service delivery operational processes, financial billing protocols, compliance reviews for CMS Corporate Compliance and HIPAA, etc. However, in a majority of cases CBHOs seem to have made few significant changes in the actual methodology used to document direct services during the past three decades.

Yet for decades, collectively direct care staff members have indicated that their primary continuous challenge has been timely and accurate “paperwork” or “documentation of services”. The never ending “keep the documentation current” challenge seems to have been a primary reason for high staff turnover/burn out rates with many CBHOs losing good and qualified staff over the years. Community behavioral healthcare is one of the few industries that effectively reveals to new, young, bright staff, “Glad you are with the CBHO. We can confirm that the first six to seven days you are with us, you will be

caught up with your paperwork/documentation….However, from the eighth day until you leave or retire, you will be behind…."

This chronic "never caught up" model has proven to create significant individual and collective anxiety among staff members leading to a generalized "overwhelmed" feeling as a result of being constantly behind in their work. A work environment where staff members are chronically "overwhelmed" challenges staff morale and their individual and collective well being.

In addition, if clinical and support staff members are chronically behind in completing, turning in their paperwork and filing documentation, then there are possibly significant compliance concerns for the CBHO. Billing services on the financial side of the organization without appropriate documentation of the service being completed and filed in the chart on the direct service side of the organization is truly a double bind non-compliance challenge that does not seem to be solvable regardless of how many hours, weeks, months and years of efforts are given.

In some cases, direct service staff acknowledge that they are weeks behind in completing progress notes for services delivered. In some cases, staff have indicated that due to the length of time between the actual service and the time when the direct care staff has an opportunity to write the progress note, the details provided by the consumer/family during the service have been lost to the "boiler plate note" that is eventually written.

Secondly, it seems that in most cases documentation of services delivered has been an exercise of an individual direct service staff writing a private note between themselves and the chart. The documentation model most used historically is not one where the service provider confirms at the end of the service, in a proactive manner, with the consumer/family the goals and objectives addressed during the session, the therapeutic interventions provided by the direct care staff and request that the consumer/family members present (as appropriate) provide their feedback regarding progress made and an indication of their perceived benefit of the service.

The historical "post" documentation model (i.e., deliver a service and after the consumer/family leaves, at some time later, document the service) has not really worked for consumers, staff and the organization for decades. Yet, there is a real perception in the industry that there is no viable documentation alternative to the never ending post documentation circular paper chase that happens every day. Perhaps no other issue has created such ill will and emotional responses among direct service and support staffs.

Even in many universities and colleges, faculty members have taught direct care staff that to write documentation while the client/family is present in the service event is inappropriate and bad practice.

During a consultation assignment in 1996 with East Alabama Mental Health Center in Opelika, Alabama, Anne Penney, Ed.D., Executive Director, and the other clinical leadership agreed to encourage direct care staff to document services at the end of the service event while the client/family were still present. And further, to take the opportunity of documenting the service as a very appropriate extension of the therapeutic interaction that could serve to focus the client/family on their next steps in the process of recovery/resiliency.

East Alabama MHC measured both staff and consumer/family responses to the "concurrent" documentation process. At a statewide training in 1997, Dr. Penney and other management team members presented audio tapes containing anonymous interviews with consumers to demonstrate the positive feedback the concurrent documentation process received. Comments such as, "I always knew my therapist was writing something bad about me when I left the session, but now I see that she is really trying to help me", or "I understand better now what my clinician is asking me to do to help myself and get better", provided great insight into the positive therapeutic relationship change that had occurred as a result of the progress notes being written at the time of service in the presence of the consumer/family.

Note: Currently numerous CBHOs are using progress note styles (i.e., the statewide clinical forms in Ohio) that provide a space for the consumer or family member (as appropriate) to sign at the end of the service his/her progress note and rate her/his level of progress achieved during the service event.

Additionally, other benefits identified from the 1996 pilot documentation program at East Alabama MHC were that staff completed their clinical documentation at the time of service which dramatically reduced the delay between service delivery date and documentation of the service. This move to a more compliant documentation submission process also reduced the number of "lost charts" that had historically been held by direct care staff "until they could write their note".

Also, the Management Team indicated that the level of staff anxiety had changed and that morale had improved as staff enjoyed the opportunity, many for the first time, of going home with their direct service and documentation work finished at the end of the day.

A great summary to the concurrent documentation pilot program was provided by Dr. Penney at the statewide training event when she shared that if she had known the magnitude of consumer, staff and system benefits engendered by the move to concurrent documentation for both in clinic and in community services, she would have changed the documentation model twenty years earlier.

Based on the positive outcomes of this initial pilot process in 1996-97 and use of the concurrent documentation process by various other community programs in succeeding years, my recommendation to numerous other CBHOs nationally is to consider the

opportunity to really change the way services are being delivered that benefits three primary areas of service delivery:

1. Enhanced consumer/family involvement/interaction in the therapeutic process to support a more recovery/resiliency focus service delivery system
2. Enhanced compliance by direct care staff with documentation submission standards and qualitative documentation requirements
3. Enhanced quality of life for both direct care and support staff through reduced anxiety as a result of being chronically behind in their documentation writing, filing and chart recall.

One of the CBHOs that acted on my recommendation to shift to a concurrent documentation process is The Mental Health Center of Greater Manchester in Manchester, NH. Below is a Case Study of outcome information provided by the its management team and participating staff which will further support the benefits of moving from a post documentation model to a concurrent documentation process. Appreciation is expressed to the following team members for their willingness to support, document and report their individual and collective findings:

- Peter Janelle, Executive Director
- Jane Guilmette, RNC, RNCNA, MHSA, CPHQ, Vice President of Quality Management
- Kristen Kraunelis, RNC, MSW, Director of Quality Management
- Kenneth Aubry, MSW, LCSW
- Catharine Main, MSW, LCSW
- Linda Powers, RN, MA, LCMHC

Case Study:
Accountable Care and The Success Oriented Services Change Initiative:
The Mental Health Center of Greater Manchester Experience.

Accountable Care Change Initiative Phase I:

During the first phase of the Accountable Care Change Initiative, the Management Team recruited fifty-two staff members that included managers, line, and support staff to form four work teams. The team focus areas were:

- Standardized Documentation Team
- Performance Standards and Revenue Team
- Enhanced Cost Efficiency, Compliance and Outcomes Team
- Organizational Support Team.

Each team was assigned a set of change “deliverables” to achieve within certain time frames. The work teams met frequently during the first year Phase One period, and all four work teams met together every few months to update each other on progress with deliverables. The work teams’ focus during this phase was to review the systems and processes that The Mental Health Center of Greater Manchester (MHCGM) had in place which support the clinician’s ability to provide direct care to clients. During Phase I, MHCGM also implemented productivity standards set forth by the Performance

Standards and Revenue Team. Competency- based performance appraisals began to be used agency-wide. The Organizational Support Team surveyed agency staff about staff workplace satisfaction, recruitment and retention. The Enhanced Cost Efficiency Team developed a consumer satisfaction survey and a standardized system for surveying consumers.

To support enhanced performance standards for staff, Teams reviewed each piece of paperwork that was required of clinicians, and revised forms to include only the necessary information. As much as possible, standardized forms were designed to be used center-wide. Team members piloted the new forms/ processes, and revisions were made based on their feedback. Once all the revisions were complete, training was provided to staff on how to use the new documents.

During these trainings, the team encouraged staff to document services during the direct care sessions, with client participation. Client signatures were not required on progress notes, but this practice was encouraged during the pilot period. The mix of direct care staff involved in the Phase I program was 50/50 clinic based and community based staff.

Leadership Implementation Model

MHCGM provided an excellent Leadership Implementation Model for its staff. The basic tenets of the Leadership Implementation Model versus the alternative Mandate Change Model are:

- Create among all stakeholders a better understanding of how complex documentation requirements under Medical Necessity qualitative audit standards can be effectively accomplished with the Client/family present
- Reduce anxiety regarding the shift to a concurrent documentation model by sharing examples of how the model is working
- Providing a mentoring environment by identifying barriers to a concurrent documentation model and action objectives used to overcome the identified barriers
- Identify and communicate benefits of the concurrent model based on enhanced client satisfaction/involvement, compliance with documentation submission and billable hour standards and improvement in the quality of life for staff
- Shift the focus:
    - From *what individual staff will lose* in order to implement the concurrent documentation process
    - To *what individual staff can gain* by using the concurrent documentation process as a tool to facilitate a more quality based compliant documentation environment.

To support the Leadership Implementation Model, toward the end of Phase I, MHCGM had a “Town Meeting” that all staff were invited to attend. During the Town Meeting, David Lloyd, National Council Consultant, facilitated a panel of six direct care staff from

various departments providing services in the office and in community settings. Each panelist shared their experiences on how the concurrent documentation process had worked for them, the barriers they met/overcame, and they gave tips about how other clinicians could implement the concurrent style of documentation for both clinic and community based service delivery. The Town Meeting was also very important to help staff not involved in the Phase I concurrent documentation process to focus on the benefits to the clients and to staff.

At the end of Phase one, approximately 18 months after the beginning of the agency's change initiative, the management team reviewed progress, and set forth new goals for Phase II.

Accountable Care Change Initiative Phase II:

Accountable Care is one very important aspect of our Success Oriented Services approach. With this in mind, MHCGM embarked on the second phase of the change initiative. The Phase I work teams gathered together for one final meeting and based on the outcome of the deliverables that these teams were able to achieve, the mission and goals for Phase II were redefined for each of the new Phase II teams. Some of the staff who were part of the Phase I teams were not members of Phase II teams and staff who had not participated in Phase I were invited to be members of teams in Phase II. The four Phase I work teams were reduced to three teams:

- Standardized Documentation Team (SDT)
- Performance Standards, Revenue and Cost Efficiency Team
- Public Relations/ Communications/ Marketing Team.

Phase II was structured operationally to function similarly to Phase I. The three work teams met individually to achieve their deliverables. Quarterly, the entire groups of teams met to review progress.

However, one of the changes made on the Standardized Documentation Team was that all members had to be willing to participate in the concurrent documentation model, and to develop the agency plan for electronic medical records implementation. Emphasis on concurrent documentation has been a top priority for the SDT. A team of "internal promoters", comprised of SDT members and other clinicians who utilized concurrent documentation, was developed to support an increase in the number of direct care staff who document in session through positive peer support, mentoring and education (Leadership Implementation Model).

Additionally, outcomes identified from the pilot program have been shared with all staff such as:

1. Direct care staff who were committed to the concurrent documentation model felt (except in the case of some community based services or crisis visits where it was not indicated) that the concurrent documentation model actually improved the therapeutic relationship. Concurrent documentation validated what the client said,

included client in reviewing and summarizing the session and the plan for the next service. The staff members who were not doing concurrent documentation were the ones who said it detracts.
2. Improved internal audits for staff using the concurrent documentation model
3. For staff using the concurrent documentation model fully there was a dramatic improvement in their quality of life. Others were at varying degrees of struggle. Many staff found it challenging to utilize concurrent documentation in community-based settings, especially when issues of privacy emerged or when children were seen without their parents present.

As a result, three new Leadership Implementation Model support components for the concurrent documentation model have been implemented at MHCGM:

1. New employee orientation now includes a module on concurrent documentation
2. Added concurrent documentation to standardized Supervision logs to keep the topic alive for both supervisee and for supervisors (to encourage supervisors to assist in removing barriers to concurrent documentation)
3. The Phase II Participants are in the process of making some "role play" videos, one to address each of the perceived barriers that other staff have expressed (i.e., "its not ethical to bill for therapy while you're doing paperwork", "it's too hard to stop the flow of conversation and start writing", etc.)

Finally, new and continuing deliverables were also established for the other two work teams, which include ensuring productivity standards were fair, making revisions to the performance appraisal for both clinical and non-clinical staff, and focusing on both internal and external marketing of services. Through these initiatives, MHCGM is confident that the organization will continue to provide quality, state-of-the-art services, thrive financially, and remain a leading community mental health provider.

Reflections, experiences, observations and recommendations from individual direct care staff that have adopted the Concurrent Documentation Model at MHCGM:

1. **Linda Powers, RN, MA, LCMHC:** Writing notes during session reinforces to the client and/or parent that I am attending to their reports of progress and symptoms, and validating their concerns. As we address the goals and objectives, the client/parent realizes that I am mindful of the treatment plan, and the degree of progress is consistently being assessed.

   Documenting my observations as I observe a child play saves time. I have found that writing the ISP (treatment plan) during session reinforces the concept that therapy is a team effort between therapist and the client(s)/family. Likewise, completing the quarterly ISP Review with the client/parent in session reinforces team effort and the therapist's attention to status of progress.

   To be timely with the ISP Reviews, if a client has DNA'ed (No Show) or cancelled the appointment when the review needs to be completed, I partially fill in the review with the information taken from previous documentations. At the next appointment,

the review is completed with the client/parent. This way, I am able to maintain compliance with submitting the review on time.

I partially complete the Annual Assessment Update and CAFAS/Eligibility with the client/parent, confirming symptoms, concerns, family living, etc, but find it easier to finish writing the documents at another time. If an appointment is not attended immediately prior to the date this information is due, I complete the documents prior to the next appointment, drawing information from recent notes. I have probably found the transition to documenting during sessions easier than some clinicians have, because my professional experience as a telephone triage nurse and as a nurse in a pediatric office prepared me to document immediately, and during interactions. However, there are times when documenting during session is inappropriate because the intensity and/or nature of the session requires total attentiveness to the client.

2. **Ken Aubry, MSW, LCSW:** My first experience with the concurrent documentation model was about a year prior to efforts at MHCGM to streamline paper work. I was at my primary care physician's office, and at the end of the visit, he took out his mini cassette and began to dictate results. What impressed me was the way he demonstrated an obvious respect for me by the way he identified specifics of the exam and his conclusions. If I had questions, he was there to answer them.

   I had a positive feeling about the experience and then when the idea of doing paperwork started to be discussed, this image helped me to give it a try. Introducing this to clients was not very difficult. I began by asking if they would like to summarize what we discussed and in particular address what was useful for them during the session and what might have been not so helpful. I found that most were very willing to participate in the process. This worked well for the progress notes, as for other forms of documentation such as treatment plans, three month reviews, and annual clinical updates: I found introducing them at the start to their treatment made for a smoother transition and became something they would be expecting to complete as treatment progressed.

   The advantages to doing much of the clinical notes and forms in session were immediately apparent. I noticed that following a therapeutic hour, I felt different. I was not burdened to quickly write a note before the next hour began. I had a few minutes to relax, stretch a little, and had time to think about the next case. The clients felt they knew more about what went into their treatment planning and found it to be a more collaborative process.

   Finally, I would not do documentation in session if the client presented with intense feelings indicating a clear need to respond. I felt it important to validate this and turning to complete documentation would be a clear distraction.

3. **Catharine A. Main, MSW, LCSW:** I like spending time with my clients. I have more than enough energy to maintain a large caseload with high productivity;

however, I could not feasibly maintain this without completing progress notes in session. I'll share with you just how I geared up and how I figured out why writing notes in session was important to me and to my clients – I actually get to spend more time with them!

About a year ago, I heard staff talking about a book, "Who Moved My Cheese?" by Spencer Johnson, MD. I told my supervisor that I'd seen the book on sale and she asked me to pick-up several copies. I thought to myself, "It must be important!" so I read the book (one of her copies); it was an easy read. I learned that I was one of those "hanger-on-ers" – I like to cling to the old. I also learned that there were many changes looming and thought I'd better prepare myself.

Completing progress notes was one of those challenges. I quickly realized that I already completed very complex behavioral analysis in session with my Dialectical Behavioral Therapy clients. We'd complete complex chains involving the most intricate links to behavior – clients readily identify links and increase their awareness. Although they sometimes dreaded completing a chain, there was no doubt that they are tremendously helpful in finding out what's being reinforced.

They like to know that I want to know every detail, just like I was watching a movie about prompting events, time, place, thoughts, feelings, vulnerabilities, timing, consequences, etc. We needed to find patterns and themes. They like my interest. They like that I jot down every detail stating, "That's important". I'm very much in connection with my clients during those times. We are both very mindful. There's energy flowing. We know where we're going in reducing or extinguishing serious and impulsive behaviors that are sometimes life threatening. Our work is very serious and we need to remember things. How could we possibly remember without writing it down?

So, the leap to writing other notes in session was not so far. Last month there was a huge reduction in my DNA (No Show) rating (13%) and, to me, that's an indication that my clients like my attention and my approach.

Frankly, I'm very proud of my productivity and the work that I do. There is no way I could see all of my clients and have high "billable hours" without efficiently completing progress notes in session. Ninety-five per cent of the time I leave work on time – I could never do that before. Staying after work hours and still not finishing my work really wore me down and I started to think, "our work as social workers is never done". The sad thing was that I accepted an almost constant fatigue. That is no longer the case and, despite our work being difficult at times, I have late afternoons and evenings to replenish.

Concurrent Documentation Consumer Satisfaction Outcomes:

A critically important component of the concurrent documentation model at MHCGM was to solicit and use the feedback from consumers/ families. Below is a brief summary of the Concurrent Documentation Satisfaction Survey evaluation outcomes for the period September 1, 2003 through August 31, 2004 which included:

A. Of 927 respondents whose clinician used the concurrent documentation practice:

1. 83.9% felt the practice was helpful.
2. 13.7% found the practice neutral
3. 2.3% disagree with the practice

B. Of the 284 respondents whose clinician did not use the concurrent documentation practice:

1. 31.5% felt the practice would be helpful
2. 36.9% felt the practice would be neutral
3. 31.3% disagree that it would be helpful

Contact Information: If you would like more information regarding the accountable care change initiative at MHCGM, please contact: Jane Guilmette at (603) 668-4111 or at her email address guilmetj@mhcgm.org. Also, you may access more information at website: www.mhcgm.org

Summary:

As indicated in the first paragraph, many Community Behavioral Healthcare Centers are facing multiple ever changing challenges. Additionally, these challenges include ensuring that services provided to consumers/families are focused on recovery/ resiliency, enhancing qualitative documentation compliance, the need to retain good staff, and, at the same time, facing the need to enhance performance levels of staff. The concurrent documentation model has proven to be very helpful to address these very complex and seemingly contradictory issues at the direct care level to the benefit of individuals (both consumers/families and staff) and therefore, the entire organization.

About the author: David Lloyd, author of "**How to Deliver Accountable Care**", has successfully facilitated the development and implementation of compliance based management accountability initiatives with over 400 CBHOs, regional medical centers, and primary care practices throughout the United States. He has been a featured presenter at numerous national, regional, state and local workshops and conferences. Mr. Lloyd is President of M.T.M. Services, LLC based in Raleigh, North Carolina, that specializes in providing management, training, and accountable care conversion services throughout the nation. Consult engagement scheduling and copies of his current book may be arranged through contacting the National Council at nccbh.org or by calling 301-984-6200.