INTEGRATING CLINICAL PRACTICE & DOCUMENTATION

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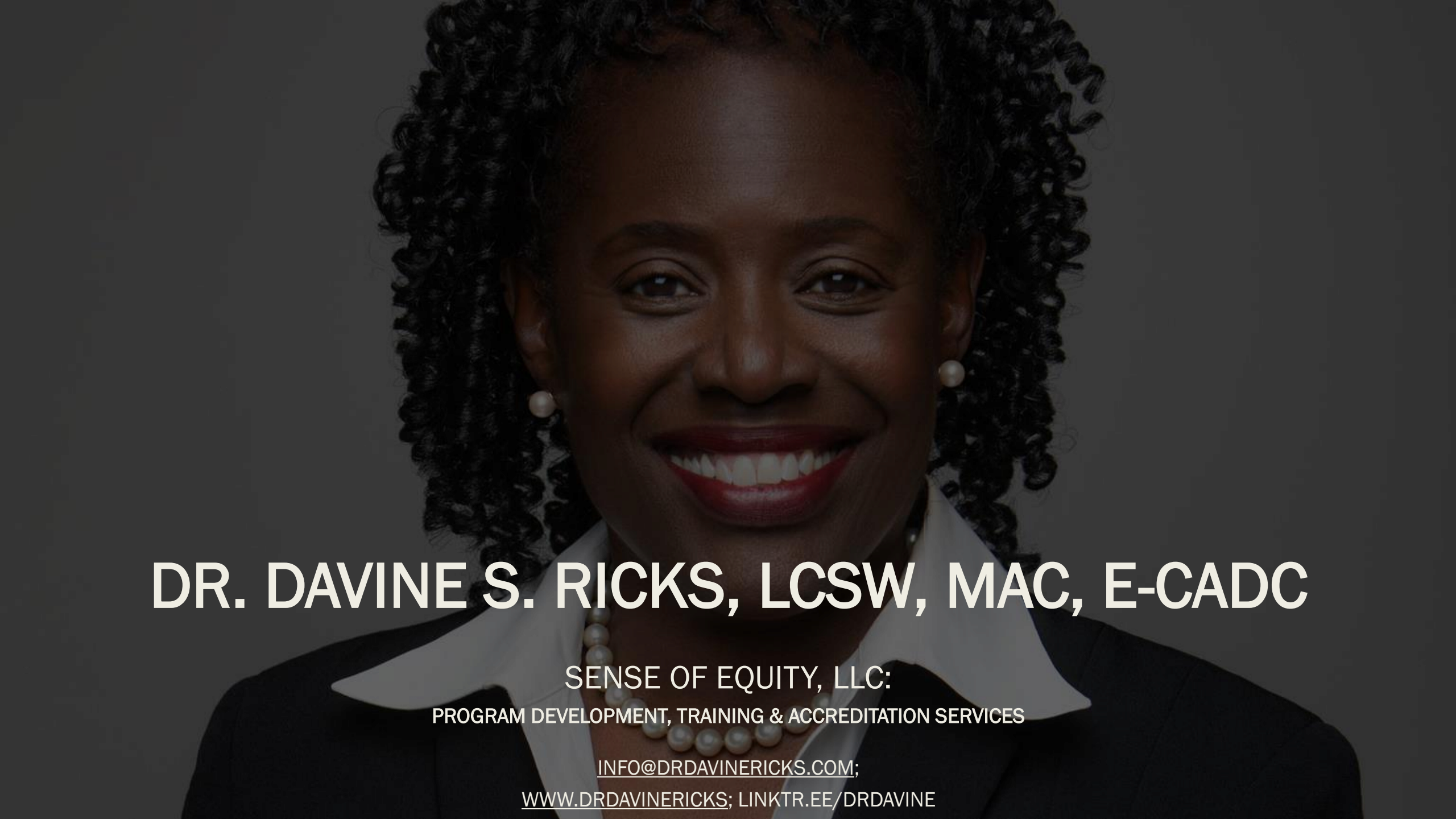
PROGRAM DEVELOPMENT & ACCREDITATION SERVICES



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Services Provided:

- Behavioral Health Program & Business Development
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Objectives

Participants will:

- Participants will enhance their skill set regarding integrating clinical practice and documentation.
- Increase their awareness of benefits of practicing collaborative documentation in clinical practice.
- Practice techniques that support timely documentation of therapeutic processes/interventions.

PRE-TEST

- Why is integrating clinical practice and documentation essential?
- What is the purpose of documentation in the treatment process?
- What is the impact of the lack of documentation regarding services provided?

EVALUATE YOUR LENS
ASK YOURSELF…

Do I think of clinical documentation as paperwork or clinical work?

Am I transparent as a provider? Am I willing and able to be more transparent?

Is my note clear, concise, yet comprehensive?

Is my language “client friendly,” so as to ensure the client can understand me?

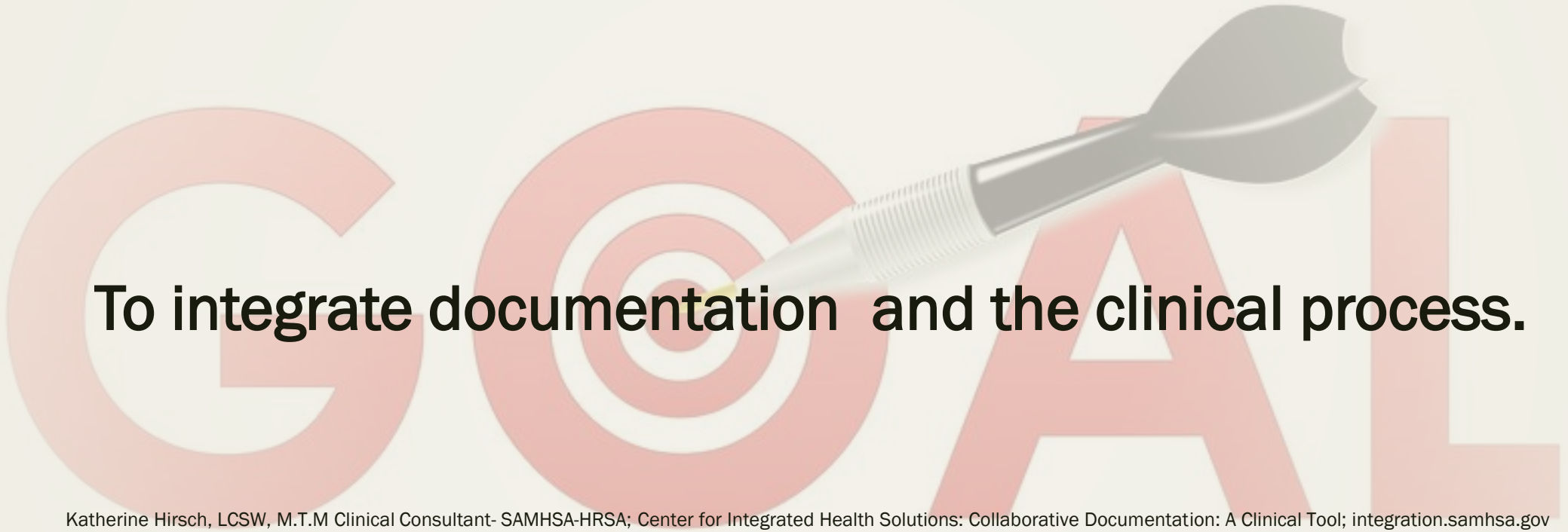
Resistance to Documentation

- Documentation is too often viewed as “The Enemy;”
- Clinicians count on “no-shows” to complete paperwork and catch up.
- Writing with the client is not billable;

IT'S ALL ABOUT THE PERSONS SERVED!!

- This is the client's chart and communication is designed to be with them and for them. Remember HIPAA regulations!
- Documentation
  - *Provides a map*
  - *Communication to treatment teams, the legal system and other authorized stakeholders as needed.*
  - *Supports continuity of care*
  - *Provides evaluation of interventions & service delivery,*
  - *Provides accountability*
  - *Supports reimbursement*

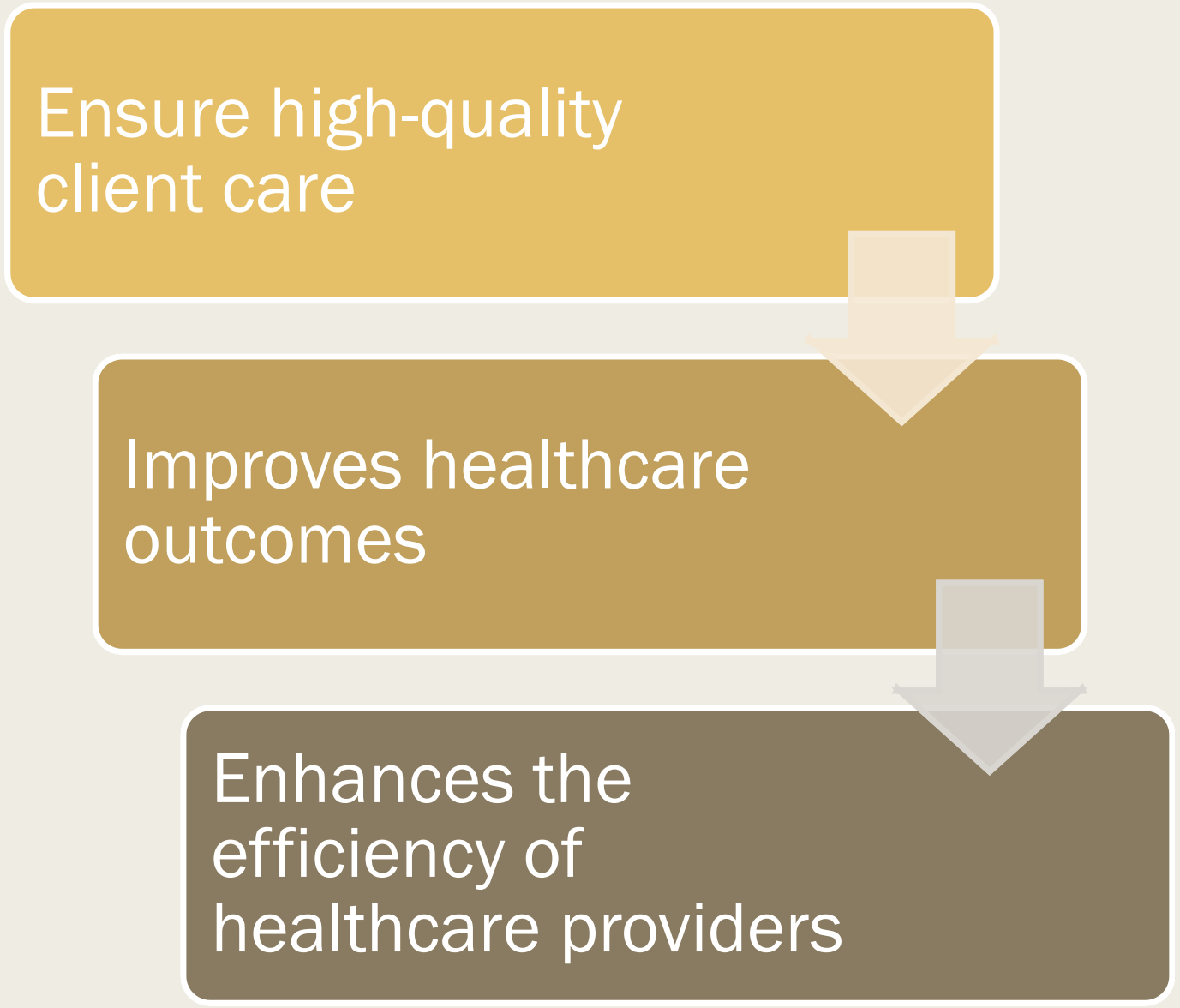
GOAL OF DOCUMENTATION



To integrate documentation and the clinical process.

Katherine Hirsch, LCSW, M.T.M Clinical Consultant- SAMHSA-HRSA; Center for Integrated Health Solutions: Collaborative Documentation: A Clinical Tool; integration.samhsa.gov

Integrating Clinical Practice and Documentation Essential



Strategies for Integrating Clinical Practice & Documentation

1. **Electronic Health Records (EHR) Systems:**
   - Implement user-friendly EHR systems to allow for seamless documentation during client engagement.
   - Customize EHR systems to fit specific needs of different specialties and practices.
2. **Real-time Documentation:**
   - Ensures accuracy and completeness of client records.
   - Utilize tools like voice recognition dictation software to facilitate quick & accurate documentation.
3. **Standardized Templates and Forms:**
   - Develop standardized templates and forms to streamline the documentation process.
   - Use checklists and protocols to ensure all necessary information is captured consistently.
4. **Interdisciplinary Collaboration:**
   - Foster communication and collaboration among healthcare team members to ensure comprehensive documentation.
   - Implement multidisciplinary rounds and team meetings to discuss and document patient care plans.

5. Training and Education:
   - Provide ongoing training on best practices for documentation.
   - Educate staff on the importance of accurate documentation for client safety, legal protection, and quality improvement.

6. Integrated Clinical Decision Support:
   - Integrate clinical decision support tools within the EHR to assist providers with evidence-based guidelines and reminders.
   - Use these tools to prompt documentation of important clinical information.

7. Efficient Workflow Design:
   - Design workflows that integrate documentation tasks seamlessly into clinical practice without disrupting client care.
   - Minimize redundancy and streamline processes to reduce the documentation burden on providers.

8. Quality Improvement Initiatives:
   - Implement quality improvement initiatives to regularly review and improve documentation practices.
   - Use data from documentation to identify areas for improvement in clinical practice and patient outcomes.

9. Patient Involvement:
   - Encourage patient involvement in the documentation process by using patient portals and shared decision-making tools.
   - Allow patients to review and contribute to their health records to ensure accuracy and completeness.

10. Leveraging Technology:
    - Utilize advanced technologies such as artificial intelligence and machine learning to assist with documentation and data entry.
    - Implement mobile and remote documentation solutions to allow providers to document care in various settings.

Key Components of Case Management Documentation in Accountability Courts

Participant Information:

- **Demographic Data:** Include participant's name, age, gender, contact information, and relevant background details.
- **Case Identification Numbers:** Use unique identifiers such as case numbers or court docket numbers.

Court Orders and Legal Documents:

- **Court Orders:** Document all court orders related to the participant, including conditions of participation and compliance requirements.
- **Legal Filings:** Record any legal filings, motions, or other legal documents pertinent to the case.

Assessment and Intake Information:

- **Initial Assessment:** Document comprehensive assessments covering the participant's background, needs, and risks.
- **Substance Use and Mental Health Evaluations:** Include results from any substance use or mental health evaluations conducted.

Individualized Service Plan (ISP):

- **Goals and Objectives:** Clearly outline the goals and objectives agreed upon with the participant.
- **Intervention Strategies:** Document the planned interventions, services, and support mechanisms.

Key Components (continued)

Progress Notes:

Session Summaries: Provide summaries of each interaction, including date, time, and duration of sessions.

Compliance and Progress: Note the participant's progress toward goals and compliance with court-ordered conditions.

Interventions and Support: Detail the interventions and support provided during each session.

Drug Testing and Monitoring:

Test Results: Document all drug testing results, including dates, times, and outcomes.

Monitoring Compliance: Record participant compliance with monitoring requirements, such as attendance at required meetings and adherence to curfews.

Treatment and Services:

Referrals: Record any referrals made to treatment programs, counseling services, or other support services.

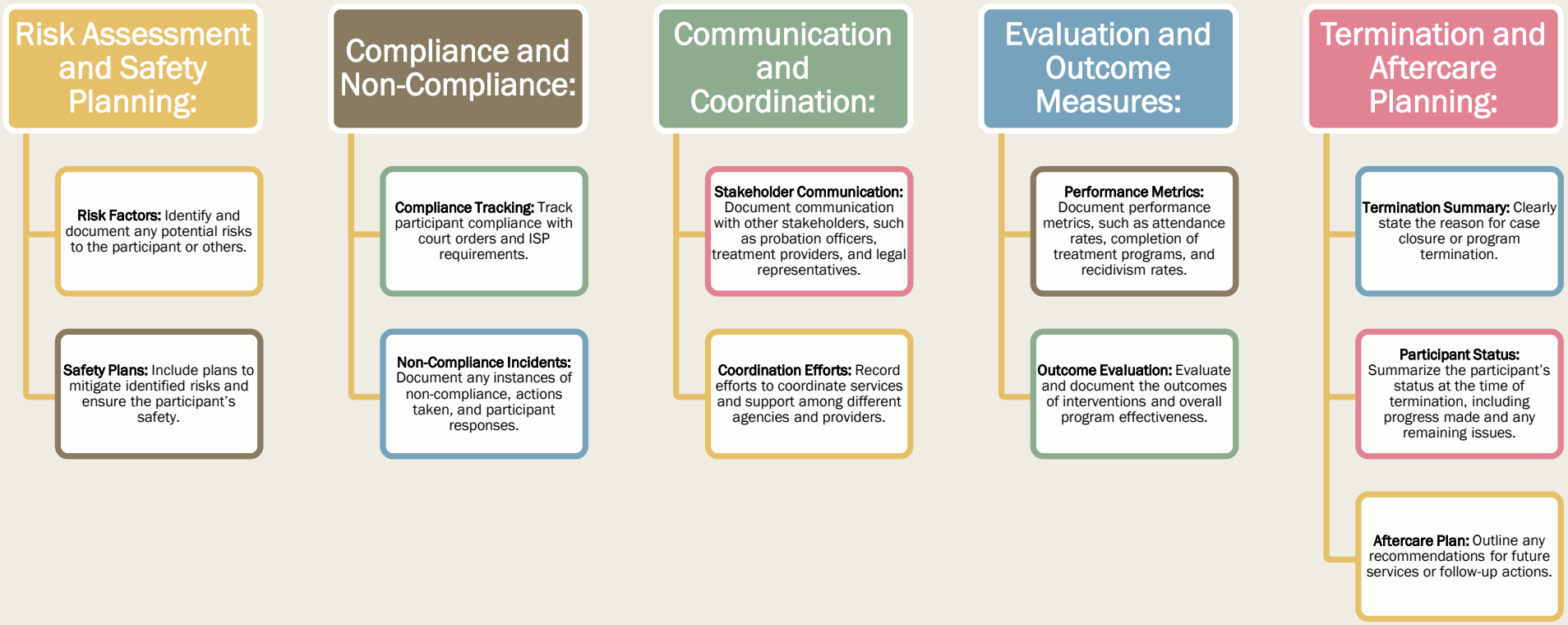
Service Provision: Document the services provided, including dates, providers, and participant engagement.

Court Appearances and Reviews:

Hearing Summaries: Document details of court appearances, including dates, outcomes, and any directives from the court.

Review Meetings: Record summaries of review meetings, including participant progress and any adjustments to the service plan.

Key Components (continued)



DOCUMENTATION

INTEGRATES THE RELATIONSHIP

BETWEEN INTERVIEWING,

ASSESSMENT & TREATMENT PLAN

Best Practices for Effective Documentation

Accuracy and Completeness:

- *Ensure all documentation is accurate, complete, and reflects the client's current condition and treatment plan.*
- *Avoid vague or ambiguous language; use precise medical terminology.*

Timeliness:

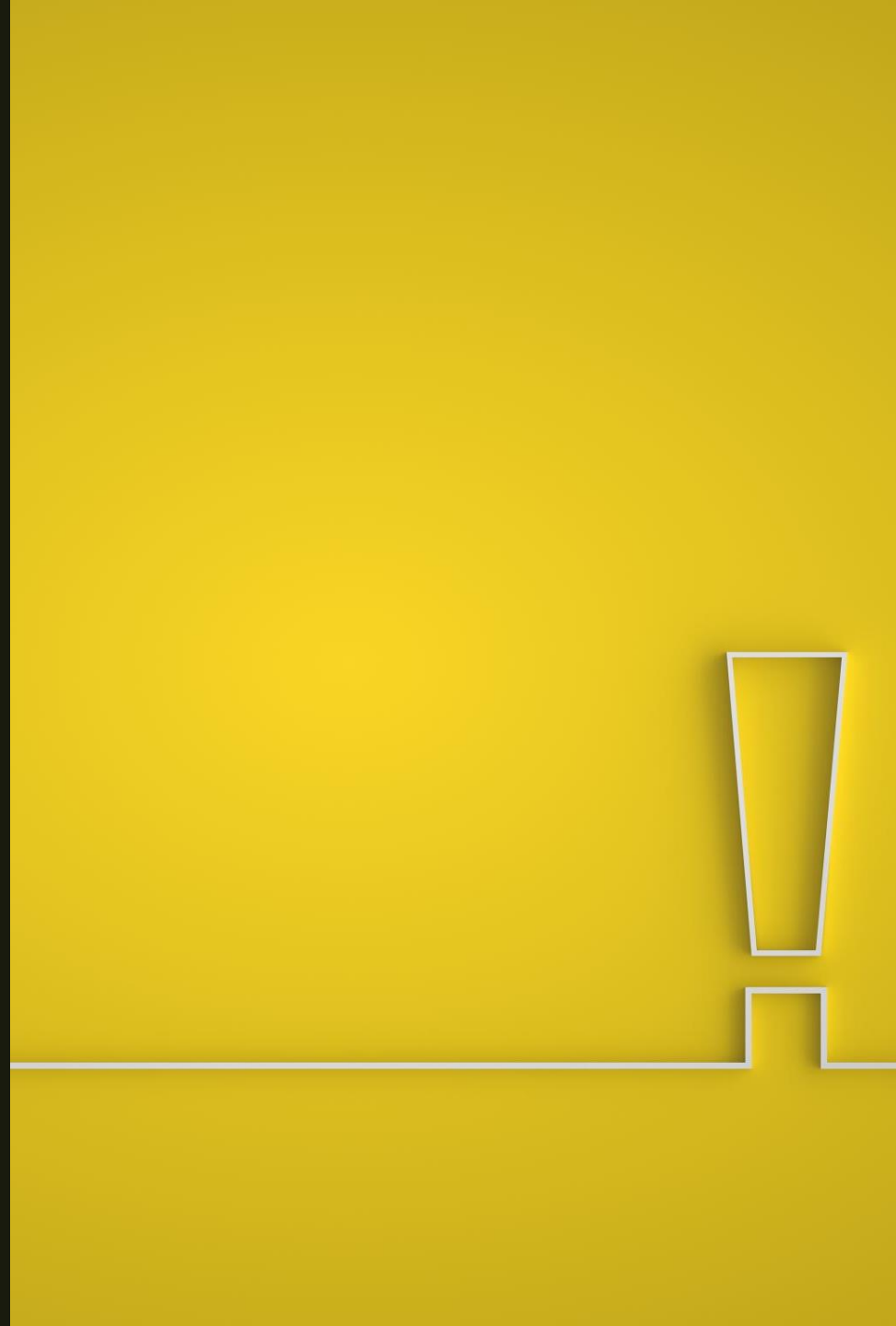
- *Document client encounters and updates as soon as possible to maintain the accuracy of records.*

Confidentiality and Security:

- *Protect client information by adhering to confidentiality and security protocols.*
- *Ensure documentation systems comply with regulatory standards such as HIPAA.*

Legibility and Clarity:

- *Ensure all written documentation is legible, clear and well-organized.*
- *Avoid using abbreviations and acronyms that are not universally understood*



Collaborative Documentation (CD) and Efficiency and Effectiveness

A process in which clinicians and clients collaborate in the documentation of the assessment, service planning, and ongoing client-Practitioner interactions, (Progress Notes).

CD is a clinical tool that provides clients with the opportunity for input.

Opportunity to share their perspective on services and progress

Allows clients and clinicians to clarify their understanding of important issues.

Bill Schmelter PhD, Senior Clinical Consultant - MTM Services; SAMHSA-HRSA; Center for Integrated Health Solutions; National Council; www.integration.samhsa.gov

Integrating these strategies and best practices…

- Improves the quality of documentation;
- Enhances client care; and
- Optimizes clinical workflows.

THE CLINICAL INTERVIEW

- Clinical interviewing is the single thread that binds an entire treatment episode together.
- It is imperative that the clinician develop his or her interviewing skills in order to help make a treatment episode effective and successful.
- The clinician should think of the interview as a "conversation with a purpose."
  Homepage.psy.utexas.edu/class/Psy364/Telch/Lectures/Interviewing

Treatment Plan

(AKA Counseling Contract)

Definition: A written, oral, or implied agreement between the client and the social worker, as to the goals, methods, timetables, and mutual obligations to be fulfilled during the intervention process.

Boyle, Hull, Mather, Smith and Farley, 2009

TREATMENT PLANS

- One of the most important tools to utilize when attempting to engage a client in treatment.
- Should be collaborative, client-driven and creative between the clinician and client that focuses on the client's view of their stated problem.
- A client driven individualized treatment plan is the basis of doing good treatment and gives the client a sense of accomplishment and success.

Key Components of the Treatment Plan

- Goals, problems and concerns to be addressed (short term and long term)
- Objectives - Specific, measurable behaviors/action steps to be tracked and changed
- Treatment methods/strategies/interventions to be used to facilitate change in behaviors/skills
- Treatment methods that will be used to accomplish/address the goals
- An estimated number of sessions required for the accomplishment of goals, problems and concerns resolution.

THE CLINICIAN'S GUIDE TO WRITING TREATMENT PLANS AND PROGRESS NOTES, For the DADS Adult System of Care; Version 5 written and edited by: Michael Hutchinson, MFT, Clinical Standards Coordinator DADS (Adult); Pauline Casper, MS, CADC II, Quality Improvement Coordinator DADS; John Harris, RADI, Clinical Supervisor Pathway Society, Inc.; Jeremy Orcutt, CADC II, Program Director ARH Treatment Options; Maria Trejo, MSW, RADI, Clinical Supervisor Proyecto-Blossoms

What is an outcome-based treatment plan?

- ❑ General statement of outcome related to an identified need in the clinical assessment.

□Impacts/benefits/intervention/efforts during and/or after participation in services/programs.

Key question in outcome based-evaluation:

☐Has intervention/service made a positive difference in client‘s problem/situation.

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CLIENT INPUT

- Treatment plans should be person-centered.
- Be aware of your personal filters. Ensure that there are not two sets of goals in counseling.
- One that the client and social worker work on together; and
- One that the social worker is secretly helping the client accomplish without the client's knowledge.

Identifying: Goals/Problems/Concerns

- **ASK:** Use Open Ended Questions
- **LIST** goals he/she would like to accomplish: *"What positive changes would you like to make in your life?"*
- **AVOID** focusing only on problems or concerns. You want the therapeutic experience to be positive as opposed to negative (strength-based).

S.M.A.R.T TREATMENT PLANS

- SPECIFIC
- MEASUREABLE
- ACHIEVABLE
- TIME-SPECIFIC

Effective Counseling Goals Should Be…

- Stated as accomplishments.
- Stated in clear & specific terms.
- Stated in verifiable terms.
- Have a reasonable chance of success.
- Adequate to improve the situation.
- Congruent with clients' value and cultural systems.
- Include a time-frame for achievement.

Prioritizing Goals

1

Identify the goal that will bring the client the most relief or satisfaction; OR

2

Identify the goal that will be the easiest to accomplish; OR

3

Work on all goals simultaneously.

4

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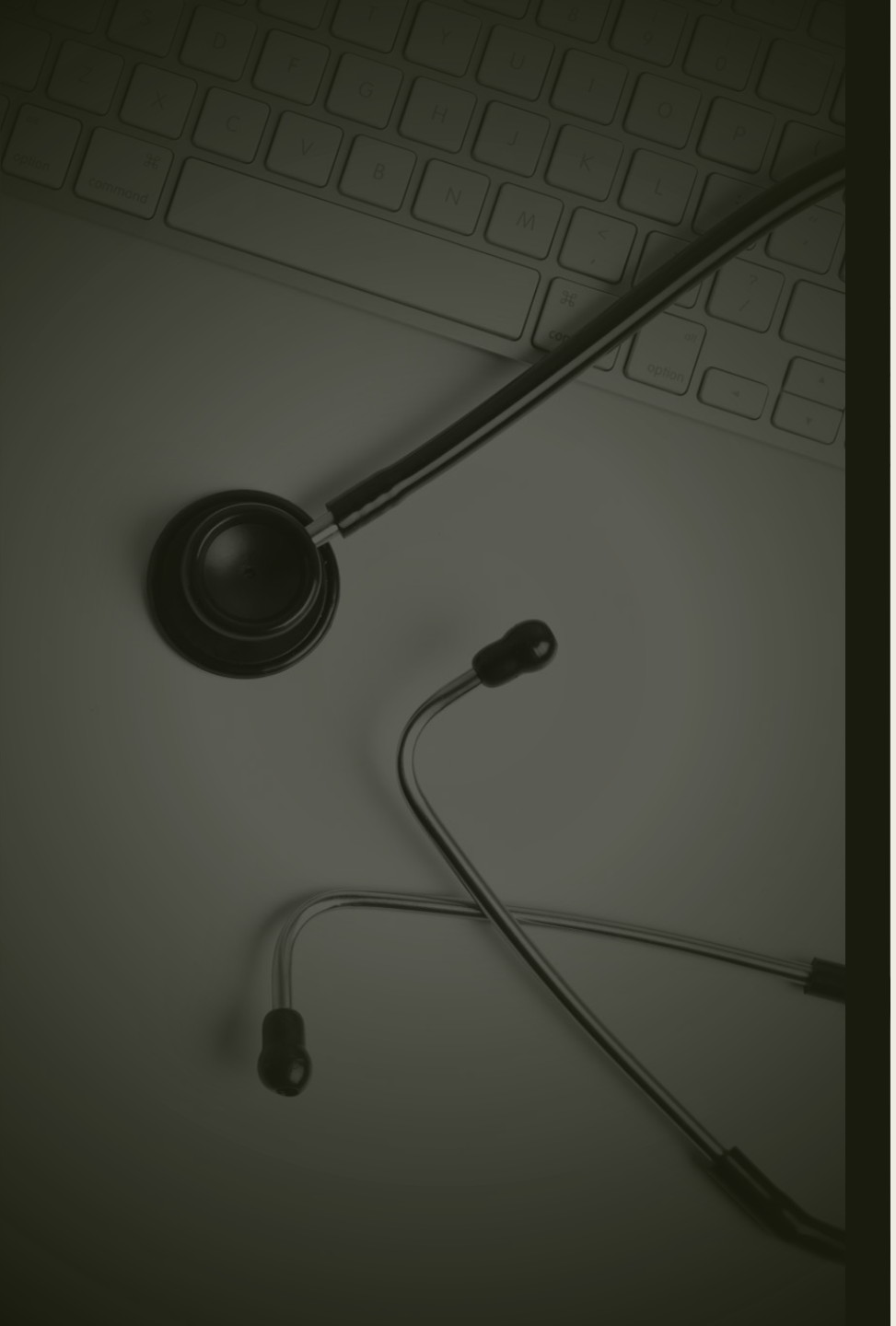

OBJECTIVES

Think of objectives as "milestones," not just as things a client will do!

Three Kinds of Changes from Baseline:

- Changes in level of understanding of an identified need;
- Changes in competencies, skills, Information;
- **Changes in symptoms, behaviors, functioning;**
- **Conditions (e.g. Level of Supports)**

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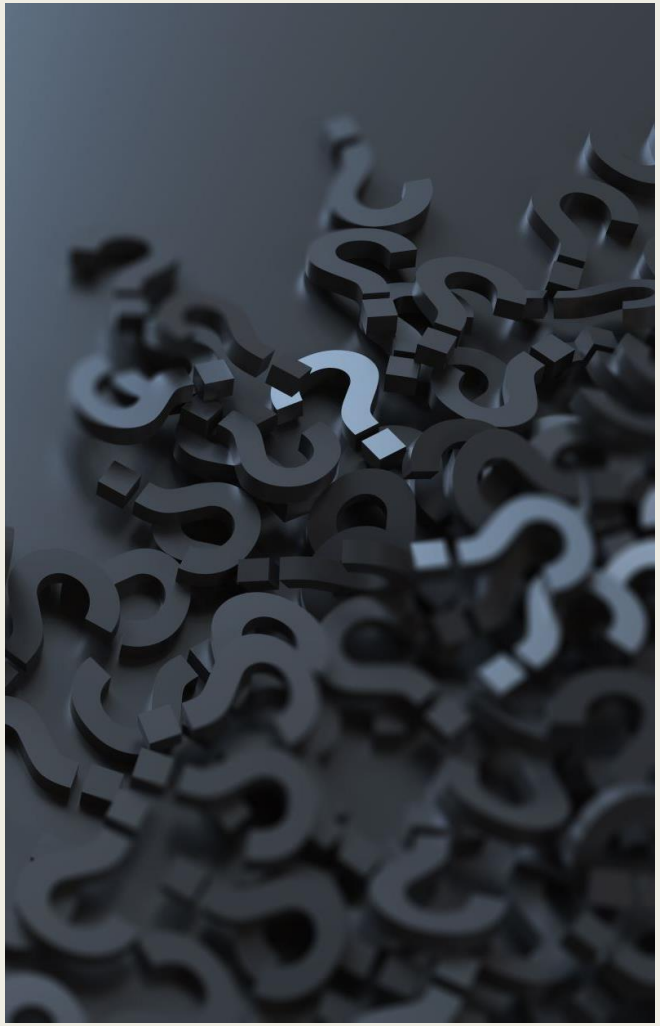

Objectives answer the key question:
Is the work that you and the client are doing together working? How do I know if I have written appropriate objectives?

Characteristics:

- Measurable
- Observable outcomes
- Apparent
- Meaningful
- Achievable in a reasonable amount of time
- Can be assessed in an objective way

Inclusion of Treatment Methods in the Treatment Plan

- What interventions/strategies will be used to help achieve the objective?
- Help the client understand that this is what you will do to help them achieve their objectives.
- Document with the client.

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Determine Number of Sessions Frequency/Treatment Dosage

Solution focused models and some other therapeutic approaches use a brief treatment model that is sometimes limited to 6-8 sessions.

Some problems cannot be accomplished or resolved in 6-8 sessions and will require extended authorizations, referrals to other community resources and/or the use of self-help resources, as appropriate;

<u>Discuss and document</u> the intervention and treatment dosage with the client.

Treatment Plan as a Fluid Document

Review treatment plan goals and objectives frequently.

Update as needed based on client input.

Initially in treatment client's may be reluctant to share their trauma and concerns. However, as they become engaged, and trust develops that may feel freer to do so.

Check in with clients to see if he/she is still wanting to work on the areas initially identified.

Treatment Plan
Documentation as a Clinical Tool

- **The plan is a much more powerful section when completed with the client.**
- Tasks or skills that the client agreed to try are noted and reviewed at the beginning of the next session. **(What is the client going to do?)**
- Tasks that the clinician agreed to complete are noted and reviewed at next session as well. **(What is the staff going to do?)**
- Topics that we did not have time to address. **(What are we going to do together at the beginning of the next session?)**

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Seal the Deal!

Get it in writing because:

- Serves primarily as a sign of commitment of the client to him/herself;
- Sign of commitment to the treatment process; and
- “Clinically, if it isn’t written, it isn’t done.”

Treatment plans set the stage for collaboration documentation of progress notes.

Having useful treatment plan goals and objectives makes collaborative documentation of progress notes easier in terms of:

Compliance – Need to relate sessions to treatment plan.

Engagement – Assessing progress helps engage and encourage clients.

Utilization of the plan as the map to treatment: If treatment plan becomes irrelevant – update it!

If objectives aren't being met – what do we need to change?

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Progress Notes: Why Are They Important

- ¨Continuity on services/care provided to client
- ¨Way to help measure progress client has made
- ¨Funding/reimbursement
- ¨Legal record of what happened

NASW Presentation By Dr. Ana M. Leon (p.37)

Basic Components of a Progress Note

- **Problem**-What does person need help with?
- **Assessment or Observation**-What occurred in the session/contact?
- **Interventions**-**What** did you provide to the client?
- **Evaluation of Progress**-is client meeting outcomes? How do you know your services/interventions are effective?
- **Plan**-What needs to happen next to help this client?

(NASW Presentation By Dr. Ana M. Leon) (p.38)

HOW DO I COMPLETE A NOTE?

- Be aware of the treatment goals and objectives before the session;
- Start every session by reviewing the previous weeks note (plan section);
- Keep the focus on “How are you doing; how are you applying what you learned to this situation?
- Break up the note (May complete mental status at beginning of the session);
- Traditional DAP and SOAP note formats are giving way to GIRPP formats (Goals, Intervention, Response, Progress, Plan).

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Progress Notes: Key Considerations

- ☐ Document high risk content: suicide, homicide, psychosis & child abuse
- ☐ Document all progress, new problems, changes, etc.
- ☐ Correcting mistakes on the note
- ☐ Time management: allow enough time for documentation
- ☐ The note as evidence of progress
- ☐The note as part of a —legaIll document
- ☐ Documentation of interventions
- ☐Coordination of the progress note with the care/service/treatment plan

NASW Presentation By Dr. Ana M. Leon (p.45)

Things to Remember When Completing A Progress Note

At end of session (time usually used for “Wrap Up”) say, “Lets review, SUMMARIZE and write down the important parts of our session today.”

1. New, salient information provided by client;
2. Changes in mental status;
3. Goal(s) and objective(s) that were focused on;
4. Interventions provided;
5. Client’s response to intervention (today) “What did we do today that was helpful?”;
6. Client’s progress re: the goal/objective being addressed;
7. Plan for continuing work.

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Write Less, Communicate Better! Clear, Concise, Yet Comprehensive

- We do not get paid “by the pound!”
- What we write should be succinct and helpful in supporting the clinical process.
- When we truly collaborate we don’t need to rely on numerous client quotes to demonstrate involvement.
- We can summarize and state only what is significant.

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REMEMBER THE BENEFITS FOR THE CLINICIAN

The clinician benefits because they are working in a collaborative relationship.

Documentation serves as a useful structure rather than just being busywork. Helps to ensure that the treatment remains on track.

POST-TEST

- Why is integrating clinical practice and documentation essential?
- What is the purpose of documentation in the treatment process?
- What is the impact of the lack of documentation regarding services provided?

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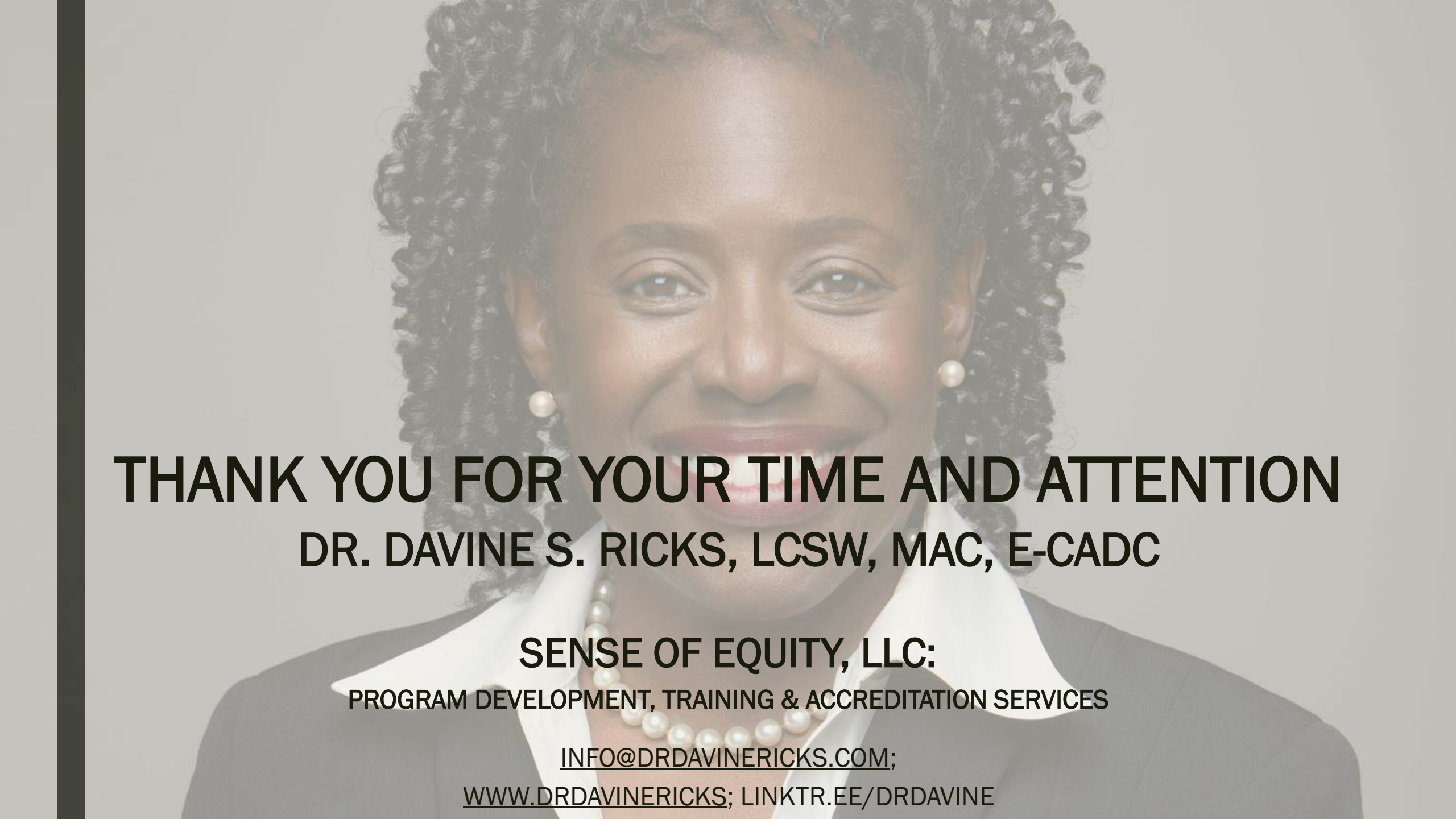

THANK YOU FOR YOUR TIME AND ATTENTION

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