Collaborative Documentation for Behavioral Healthcare Providers: An Emerging Practice

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Abstract

As a result of recent federal legislation such as the Health Insurance Portability and Accountability Act (PL 104-191) of 1996, the American Recovery and Reinvestment Act (ARRA) of 2009, and the Patient Protection and Affordable Care Act (PL 111-148) of 2010, significant changes have occurred in the provision of behavioral health services. One of the most substantial changes has been the adoption of electronic health records (EHR). Emerging from an increased use of EHR technology, collaborative documentation (CD), is a model for concurrently documenting content and process whereby providers and clients collaborate in creating intake and assessment summaries, treatment or service plans, and progress notes. Strengths of CD include a stronger therapeutic alliance, shared decision making for treatment options, and greater accuracy in documentation.

Collaborative documentation (CD), an innovative practice for behavioral health service providers, is a process whereby providers and clients collaborate in creating intake and assessment summaries, treatment or service plans, and progress notes (Hirsch, n.d., Schmelter, 2012). Heralded as "a very effective quality improvement tool and a compliance strategy in response to enhanced external accountability requirements and as a means for strengthening the therapeutic or working alliance," CD has emerged following significant legislative and technological changes in healthcare delivery (DiCarlo & Garcia, 2016; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d., p.3). This article will investigate CD and the milieu in which it developed, the attributed benefits providers and clients, and the available research support for its use. In conclusion, future directions for education, practice, and research will be explored. For this article, the authors use the term collaborative documentation (CD) although the term concurrent documentation (CDoc) may be used interchangeably (Schmelter, 2012). As Kaufman (2012) notes, "No distinction between the two terms is apparent in the limited literature" (p. 3).

Legislative and Technological Roots

Recent legislative developments have dramatically changed the landscape of healthcare delivery and contributed to the climate from which the concept of collaborative documentation has emerged. The Health Maintenance Organization (HMO) Act of 1973 (PL 93-222) promoted the development of HMOs to improve the delivery of healthcare services to clients while controlling costs. In 1996, the Health Insurance Portability and Accountability Act (PL 104-191) was enacted to address coverage of and restrictions on benefits for pre-existing conditions, as well as to define policies and procedures for protecting the security of private health information (PHI). Enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA), the Health Information Technology for Economic and Clinic Health (HITECH) Act was created to promote the adoption of electronic health records (EHR) and

related technology. In addition, HITECH strengthened the privacy and security protections of HIPAA, increased the legal liability for noncompliance, and enhanced enforcement. Most recently, the Patient Protection and Affordable Care Act (PL 111-148) was enacted in 2010 to improve healthcare outcomes through improved practice, lowered costs, increased accessibility and national standards for electronic health care.

Electronic Health Records

In recent years, significant legislation and technology have facilitated the use of electronic health record (EHRs). As a result, more and more heath care organizations have adopted some form of electronic medical records system. Driven by the goals of cost containment, increased accuracy and efficiency, enhanced access for consumers, and improved collaboration and communication among providers, EHRs have made the storage and retrieval of large volumes of patient information easier and more accessible (DiCarlo & Garcia, 2016; Grantham, 2010).

In a quasi-experimental study initiated in 2010, approximately 105 primary care physicians from Beth Israel Deaconess Medical Center in Massachusetts, Geisinger Health System in Pennsylvania, and Harborview Medical Center in Washington invited 20,000 of their patients to review notes written by their physicians after an office visit. Funded primarily by the Robert Wood Johnson Foundation, the Drane Family Fund, the Richard and Florence Koplow Charitable Foundation, and the National Cancer Institute, the study was the beginning of OpenNotes, a non-profit movement advocating for greater transparency and accessibility in health care. The underlying principle is "Nothing About Me without Me," reflecting the importance of shared decision-making in health care, which arose from the Salzburg Global Seminar in 2001 (Delbanco, et al., 2012; "Our History," n.d.).

In the OpenNotes study, a significant majority of the participants read at least some of the notes written by their doctors and indicated that the openness of their medical records would affect their

future decisions about health care. Of the participants who completed surveys, approximately 99%

supported continuation of the transparent practice and reported benefits, such as increased

understanding of their health concerns and improved adherence to treatment plans including

medications, as well as a greater sense of involvement and control in their health decisions. Notably,

most participants were not worried, confused, or offended by physicians' comments in the medical

records (Delbanco, et al., 2012).

Protected by HIPAA (1996), behavioral health records were not originally part of the electronic

health records (EHRs) movement. Under HIPAA guidelines, psychotherapy notes do not have to be

released to the client if the provider believes it would be detrimental to the client's well-being.

Providers have hesitated to share mental health records with clients out of concerns that clients might

not understand or might misinterpret a note or that clients might feel judged by their providers

(Delbanco, et al., 2010; Denneson, Cromer, Williams, Pisciotta & Dobscha, 2017; Kahn, Bell &

Walker, 2014; National Council for Community Behavioral Health, 2012). However, as EHRs

proliferate, more providers are including behavioral health documentation in electronic medical records

systems. In 2013, the Department of Veterans Administration added several features to VA Blue

Button, the personal health record component of My Heath*e*Vet, a self-service online platform. One of

the features was access to behavioral health records (Department of Veterans Affairs, 2013). As part of

the OpenNotes expansion in 2014, Beth Israel Deaconess in Boston began including mental health

records in EHRs where they can be easily accessed by clients (Kahn, Bell, & Walker, 2014;

Kowalczyk, 2014; "Our History," n.d.; Ritter, 2014). In the Delbanco et al. OpenNotes study (2012),

physicians also addressed mental health and substance abuse issues in the participants' records. Despite

the inclusion of behavioral health information in EHRs by these groups, behavioral health care

providers have been slower to adopt more accessible and transparent systems.

Ideally, the use of EHRs enhances behavioral health outcomes through more accurate and efficient documentation, coordination of services, monitoring of diagnoses/symptoms, and consultation among providers. Behavioral health providers have access to comprehensive medical records allowing them to collaborate with prescribers and observe medication effects, track psychotherapy interventions, and consider the overlap among medical and mental health conditions. In addition, the use of EHRs improves efficiency through more accurate and timely documentation, improves risk management through shared information, and reduces the workloads in general through streamlining administrative processes (Grantham, 2010; Schmelter, 2014; Steinfeld and Keyes, 2011).

Speaking to the benefits of EHRs in behavioral health care, Grantham (2010) pointed out, "Through logic capable of locating and associating thousands of diagnoses, diagnostic codes, treatment requirements, related treatment codes, and countless other bits or bytes of information, EHRs help providers coordinate activity efficiently" (p. 33) through the concept of the golden thread. The golden thread is the idea that each step of documentation flows logically and naturally from the previous step and should be connected in a manner that supports and justifies each action while building a comprehensive, integrated record of service provision. Assessment identifies critical needs, treatment/service plans address relevant goals and objectives identified during assessment, and interventions are selected to facilitate accomplishment of goals and objectives based upon critical needs. Documentation such as progress notes reflects the client's efforts and movement toward accomplishing specified goals and objectives. When completed accurately and meticulously, a golden thread of connectivity should be evident in the documentation of service provision (Colorado Committee on Quality and Compliance, 2011; Grantham, 2010; Schmelter, 2010).

Shift Toward Client-Centered Behavioral Health Care

Despite the acknowledged benefits, Kahn, Bell and Walker (2014) suggest that behavioral health care

providers' resistance to transparency in EHRs may stem from two areas of concern: (a) negative reactions by clients to the providers' comments and (b) belief that clients may be unwilling or unable to challenge inaccuracies or misrepresentations in the notes. In the Delbanco study (2012), a significant minority of physicians reported modifying language addressing potentially sensitive issues, such as mental health, substance abuse, obesity, and cancer in their notes knowing that patients would be reading what was written. Because of concerns regarding client reactions to information in their EHRs, many providers describe shifting the emphases in their notes from labeling to describing, not eliminating clinical terms, but balancing them with more personalized phrases (Kowalczyk, 2014). In a 2017 study of Veterans Health Administration behavioral health providers, Denneson et al., found that clinicians were making similar adjustments to documentation based upon concerns for clients, as well as an awareness of the expanded audience for electronic records. While the practice of allowing clients to view their EHRs remains somewhat controversial or uncomfortable for some providers, it has influenced service delivery in a more client-centered direction (Denneson et al., 2017; Heath, 2017; Kahn, Sigall, Bell, & Walker, 2014). Collaborative documentation is clearly situated in this movement toward a more client-centered provision of services that includes enhanced client engagement and increasingly transparent documentation written in non-judgmental, descriptive language in balance with diagnoses, clinical terminology, and treatment goals.

The Emergence of Collaborative Documentation

One of the initial and most fervent advocates for the practice of collaborative documentation has been the National Council for Behavioral Health. A not-for-profit 501(c)3 organization, the National Council serves as an advocacy, lobbying, and training group for its more than 2800 mental health and addictions treatment member organizations ("About the National Council," n.d., para. 1). MTM Services, a consulting firm affiliated with the National Council, has been the predominant vehicle for promoting

and training providers in the practice of collaborative documentation (DiCarlo & Garcia, 2016). Providers in Illinois, Missouri, Oregon, Texas and other states have embraced collaborative documentation (Grantham, 2010; Missouri, 2011; MTM Services, 2013).

Collaborative documentation is a model for concurrently documenting content and process while providing behavioral health services. It incorporates the goal of a strong therapeutic alliance with the concept of shared decision-making between providers and clients and the technology of electronic health record systems (EHRs). Clients and providers create a service provision record in a transparent, collaborative process throughout the face-to-face session. Due to the increased use of EHRs, most collaborative documentation is completed using a laptop or desktop computer. At the beginning of service provision, providers work through intake and assessment forms as they listen to clients, completing one section at a time, summarizing the information, and presenting it to clients for input and approval before moving to the next section. During the development of the treatment or service plan, providers question clients about their personal needs and goals and work jointly with them to combine their goals with traditional behavioral health goals. At the end of each session, providers work in a reciprocal manner incorporating their clinical judgment with clients' perspectives to summarize the goals addressed and interventions utilized during the encounter and to plan for subsequent sessions. (DiCarlo & Garcia, 2016; Hirsch, n.d.; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter, 2012).

Rationale for Collaborative Documentation

Challenging or changing long-standing practices often encounters resistance; however, practice changes must accompany paradigm shifts in the provision of services. As the utilization of electronic health record systems and greater transparency in behavioral health records have facilitated a paradigm shift from practitioner-focused to client-focused practice (Heath, 2017), collaborative documentation offers

another shift in the logistics of practice. Clearly compatible with EHRs and illustrative of transparency in service provision, CD introduces a method of documentation that is client-centered and contributes to improved therapeutic outcomes (Falkenström, Granström, & Holmqvist, 2013; Quaschning, Korner, & Wirtz, 2013; Thompson & McCabe, 2012).

Identifying the benefits of Collaborative Documentation assists in its adoption and implementation. A stronger working or therapeutic alliance; increased client engagement and improved outcomes; and more effective time management, greater cost effectiveness, and enhanced quality of work-life for providers are among the more significant benefits associated with CD by those promoting the practice, as well as those who have implemented it (Grantham, 2010; Schmelter, 2012).

Therapeutic Alliance, Client Engagement, and Outcomes

Described as the strength of connection between provider and client, the working alliance has long been perceived as key in the therapeutic process (Bordin, 1983). Defined by Bordin in 1979 as "an agreement on goals, an assignment of task, and the development of bonds," the concept remains a valued component of psychotherapy regardless of school or orientation (DiCarlo & Garcia, 2016). Historically, proponents of the concept of a therapeutic or working alliance believed that it was the primary curative factor, valuing modality second (Falkenström, Granström, & Holmqvist, 2013). Researchers have found it to be one of the strongest and most reliable predictors of positive client outcomes (Bedi, Davis, & Williams, 2005; Duncan, Miller, Wampold & Hubble, 2009, Horvath, Del Re, Flückiger, & Symonds, 2011). While comprised of three important factors: mutual agreements, tasks, and bonds, Bordin (1983) maintains that the strength of collaborative agreement, through clarity and equal contribution, is directly proportional to outcomes. In most instances, the working or therapeutic alliance is improved with a collaborative process (Thompson & McCabe, 2012).

Person-Centered Planning is a process of collaboration with clients to develop individualized plans for services (Stanhope, Ingoglia, Schmelter, & Marcus, 2013). Relying on the identification and inclusion of the client's values and preferences (Jesus, Bright, Kayes, & Cott, 2016), the person-centered approach strengthens the working alliance via increasing client involvement in the treatment process. By working *with* the client instead of *for* the client, the approach gives voice to the client through a show of respect. Through a person-centered process incorporating their voice, collaborative documentation enhances clients' sense of empowerment and lessens their fear or distrust thereby strengthening the relationship (Kaufman, 2012).

In addition to a strong working alliance, increased client involvement in shared decision-making and the treatment process improves outcomes. Falkenström, Granström, & Holmqvist (2013) found that a positive therapeutic alliance had a significant impact on adherence and, therefore, treatment outcomes. Other research indicates that increasing client involvement in treatment choices positively impacts adherence leading to better outcomes (Quaschning, Korner, & Wirtz, 2013; Thompson & McCabe, 2012). Proponents of collaborative documentation, a client-centered process predicated on shared decision-making, submit that it could also contribute to increased adherence (Schmelter, 2013).

Another substantial benefit derived from utilizing collaborative documentation is the impact it has on client satisfaction and engagement. In a large-scale sampling of mental health clients, 82% of those surveyed, reported that the practice of CD was either "helpful" or "very helpful" with a significant majority indicating they would view the practice approvingly in subsequent healthcare situations (Schmelter, 2013). Satisfaction with their level of involvement has an impact on adherence, as well as health status (Ferguson, Ward, Card, Sheppard & McMurtry, 2013; di Palo, 1997). Engagement in the care process is also linked to client motivation, readiness, and increased function

(Simpson, Rowan-Szal, Joe, Best, Day & Campbell, 2009). Not only do clients report greater satisfaction and fulfillment using CD, providers do as well (Mistler & Drake, 2008).

Immediacy and Intersession Processing

Collaborative documentation is also a valuable tool for addressing immediacy and reviewing or processing interventions. Immediacy is a concept from psychoanalytic theory and is used to describe the therapeutic process of working through transference or countertransference (Kasper, Hill, & Kivlighan, 2008). More recently, Mayotte-Blum (2012) has described therapeutic immediacy as a discussion between a client and a practitioner that could include aspects of the session, such as the client's cognitive or affective reactions to interventions, the practitioner, and so on. Regardless of school or orientation, CD provides a vehicle for immediacy as the practitioner and client review and document the session content. Research has shown that the practice of immediacy can produce feelings of being cared for and create a space for expression in a safe, systematic manner (Kasper, Hill, & Kivlighan, 2008).

Processing an intervention, typically emphasized in professional training for behavioral health care providers, reviews and assesses the effectiveness of interventions used during service provision. In practice, anecdotal reports suggest that this process is neglected due to time constraints and the demand for provision of billable services. Intersession processing, a similar practice by clients of reflecting upon the content of a session between sessions, has been shown to be an important factor in producing greater improvement and better outcomes supporting broader generalizability of new information or skills (Hartmann, et al, 2016; Owen, Quirk, Hilsenroth, & Rodolfa, 2012). Although there is an absence of research on how to encourage intersession processing (Owen, Quirk, Hilsenroth, & Rodolfa, 2012), there is evidence to suggest that a strong working alliance is related to an increased understanding of the meaning of the interventions utilized during direct service provision. As such, intersession

processing and generalization of skills could be promoted through collaborative reflection and synthesis of the session content through a practice like collaborative documentation (Owen, Quirk, Hilsenroth, & Rodolfa, 2012). Related to this result, evidence supports that review of interventions through on-going client feedback can detect relationship or approach problems and prevent premature termination (Reese, Norsworthy, & Rowlands, 2009). CD also formalizes and operationalizes a review of the session. The practice creates an opportunity for the client and practitioner to review content of a session, to improve client understanding and application of new information, and to strengthen the therapeutic alliance. It also helps to ensure that the client and practitioner end the session of service provision with the same understanding.

Improved Time Management and Increased Cost Effectiveness

Perhaps the most beneficial impact of collaborative documentation for behavioral healthcare providers is greater efficiency and better time management. Some reports indicate that mental health providers spend more than 20% of their time on documentation (Carise, Love, Zur, McLellan, & Kemp, 2009). Because documentation is not a reimbursable service, the burden falls on behavioral healthcare providers to complete this requirement at the end of the day, after hours, or during times when services could be offered. 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.

Just as goals of cost containment, increased efficiency, and enhanced access for consumers have driven the utilization of electronic health records (DiCarlo & Garcia, 2016), cost efficiency and a reduction in ineffective service provision are priorities for behavioral healthcare providers. As the

demand for evidence-based practices has risen, a reduction in the number of sessions allowed by state and third-party payers has followed (Steenbarger & Smith, 1996). In an attempt to address business and treatment concerns simultaneously, many states and behavioral health providers have adopted the practice of Collaborative Documentation (Colorado Committee, 2011; Grantham, 2010; Missouri, 2011). As transparency in health records and the use of electronic medical records systems increases and as providers become more comfortable and proficient in the practice of shared-decision making in healthcare provision, CD offers a vehicle for addressing administrative, evaluative, and therapeutic goals.

How to Use Collaborative Documentation

The practice of collaborative documentation is simple to initiate and should flow naturally from the interaction between the practitioner and the client during the orientation and informed consent discussions of the initial intake or assessment session. Presenting its benefits and describing the process sets the stage for the implementation of CD. If necessary, clients should be given the opportunity to ask questions or clarify their understanding of the process. The example below illustrates a discussion regarding implementation of CD at an initial contact.

> In our session today, I will be completing your assessment. This will include . . . (description
> of assessment process). Have you ever wondered what a physician or other healthcare
> provider writes in your medical record after you leave? Well, today as we talk and before you
> leave, we will create a record of the services you received using a technique called
> collaborative documentation. This means that we will work together to create a record of
> what happened today and at each appointment in the future also. As we talk, I will be
> typing/recording the information you provide to ensure the most accurate
> record/documentation. From time to time, I will ask you for quotes to guarantee I record

exactly what you are thinking or feeling in your own words. Because we will be using collaborative documentation, you will always know what is being written in your records. In our future appointments, we will spend the last few minutes of each session completing the notes together. You will have the opportunity to tell me what you found helpful about the session, what you liked or did not like, and how what we did worked for you. It will also give me a chance to clarify our goals and ensure we agree on the plan for the coming week(s). Do you have any questions about collaborative documentation?

The next example demonstrates how a provider might introduce a client to collaborative documentation after the initial session or following an intake or assessment session by another provider. It also demonstrates an opportunity to compare a new process with a former process especially if the practice is being introduced to an existing client or to a new client who has interacted with other behavioral healthcare providers.

Are you aware that your healthcare providers write a summary note about each of your appointments after you leave? After our previous sessions, I have done that also; however, today we are going to begin using a different technique called collaborative documentation. This means that you and I will work together to write a summary note of what we talk about and do today in the last few minutes of our sessions. By documenting our sessions this way, you will know what is going into your records. I will ask you to tell me your thoughts about the session, what you liked or did not like, and how it worked for you. Writing this summary together will give us a chance to check our understanding of all that we have done and said in our session and ensure that we agree on the plan for the coming week(s). Do you have any questions?

Collaborative documentation can be used with almost any type or format of practitioner-completed documentation, such as progress notes (e.g. SOAP, DAP, and BURP). Other types of documentation that can be used with CD include demographic forms, initial assessments/intake forms, assessment updates, wellness/treatment plans and updates, diagnostic/psychiatric evaluations, and discharge or transfer summaries. Regardless of the form of documentation, the record is created through collaborative interaction incorporating both the practitioner's and the client's perspectives. Table 1 offers an example of a SOAP note with sample prompts.

Table 1
Using Collaborative Documentation with a SOAP Note Format

Component of SOAP Format		Example of Documentation with Sample Prompts for Eliciting Client Contributions
(S) Subjective	**PROVIDER describes client presentation**	Client presented in jeans and a tee shirt. Client appeared to have a positive mood, with head up and smile on.
	CLIENT describes his/her understanding of concern and experience of session	**Sample prompts:** How would you summarize what we did today? What did you get/learn from our work today? Is there anything else you would like to add? **Client reported:** We talked about my relationship with my mom, walking, and my good mood, and my cat. We talked about my sister, my grandma, and me. We talked about new Mary and old Mary. I think new Mary is going to be a lot better. Old Mary drank and lied a lot. We talked about things I like about myself. We talked about my goals. I liked what we did today."
	PROVIDER leads completion and adds to client quote	Client presented and discussed issues and activities from her previous week. Client talked about grief due to loss of function. Client identified current positive attributes. Client explored helpful tools she has used to establish and preserve safe boundaries with others and to maintain de-escalation.
(O) Objective	**PROVIDER makes observation and leads completion of documentation**	Client appeared generally comfortable and open to feedback with moderate insight; congruent affect *WNL; regulated mood WNL; oriented x4. Client's observable speech was slurred due to functional limits. No suicidal ideation or homicidal ideation was reported or observed. Client appears to be in action stage of change.

Table 1		
Using Collaborative Documentation with a SOAP Note Format (cont.)		
Component of SOAP Format		**Example of Documentation with Sample Prompts for Eliciting Client Contributions**
(A) Assessment	PROVIDER describes action of session	Provider assisted client in identifying de-escalation and coping skills that have contributed to improved mood. Provider assisted client in identifying her positive attributes to reinforce gains and support change. Provider assisted client in generalizing gains to other areas of her life. Provider supported client as she processed grief about change in function (accommodation and assimilation of disability).
(P) Plan	CLIENT describes plan and leads completion of documentation	**Sample prompts:** What's the plan for this coming week? What will you be doing/practicing this week before our next appointment? What is your homework? Client will continue to practice and implement drawing/feelings journal, practice counting and other identified de-escalation skills; client will utilize grounding for obsessive thoughts. Client will identify at least one additional positive attribute to add to her strengths list. Client will return next week.

*WNL – Within Normal Limits

Future Directions for Research

Peer-reviewed research examining the process of collaborative documentation is sparse. A search for "collaborative documentation" or "concurrent documentation" in the electronic databases Academic Search Premier and PsycINFO yielded one study related to the practice of CD in behavioral healthcare service delivery. The sole study reviewed the practice of CD in combination with person-centered planning (Stanhope, Ingoglia, Schmelter & Marcus, 2013) and found that clients receiving services utilizing client-centered planning and collaborative documentation were more engaged in services and had greater adherence to medication regimens. Anecdotal and non-peer-reviewed reports of use by behavioral healthcare providers are more numerous (Colorado Committee, 2011; Grantham, 2010; Kaufman, 2012; Midwestern Colorado, n.d.; MTM Services, 2013; Schmelter, 2013).

Future clinical research on the process of collaborative documentation should focus on factors, such as the therapeutic or working alliance, client engagement and satisfaction, shared decision-making and other client-centered practices, treatment adherence, and treatment outcomes. The impact of cultural variables, such as race/ethnicity, age, and socioeconomic status, as well as the severity of clients' health concerns on the practice needs to be studied as well. Because the National Council for Community Behavioral Health and MTM Services have been the predominant advocates for the practice of collaborative documentation, it is crucial that future research maintain an unbiased perspective and include the voices of service providers and clients. In addition to clinical perspectives, the practice of collaborative documentation should be studied from a logistical and financial perspective. Because CD has emerged in a time of increased technological innovation, the impact of technology including the use of CD on client satisfaction and outcomes, the working alliance, and practitioner satisfaction are all areas to examine. Beyond these considerations, the use of computers with the ensuing need for new software and capabilities, adequate protection, and reconfiguration of spaces for service provision must be considered. Logistically, studies must examine if, and when, collaborative documentation is more cost effective, accurate, and efficient. From an educational perspective, research should focus on training and implementation for current and future behavioral healthcare providers. Educators must be prepared to train students to incorporate technological tools, such as electronic health records into competent, ethical, and compassionate service delivery. The role of collaborative documentation and other collaborative practices in the provision of these services also needs additional study. The opportunities for research involving the practice of collaborative documentation are varied and numerous. What appears on face value to be a beneficial practice, awaits empirical support.

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