Concurrent Documentation - Change Initiative Report

Midwestern Colorado Mental Health Center

Introduction

After engaging in an agreement with David Lloyd, a nationally known consultant on mental and behavioral health practice, the Midwestern Colorado Mental Health Center (MWCMHC) undertook a "Change Initiative" to address numerous areas of the agency's policy, procedure and practice. This change initiative was guided by the consultant and a mutually-established Project Management Plan, which involved the creation of four Performance Teams to facilitate and participate in the change initiative process. One of these Performance Teams was the Standard Documentation Team (SDT).

According to the Project Management Plan, the SDT responsibilities were to:

- Review all of the organization's currently used documentation to determine efficiencies and Medical Necessity Linkage needs.
- Measure current level of documentation timeliness
- Establish current documentation to Direct Service Ratio
- Design training and education programs to address any timeliness and/or ratio challenges
- Develop implementation plan including forms development and maintenance model for future
- Develop Core Competency Training Plan for concurrent documentation model and other core competencies needed for new form processes.

Initially, the SDT tackled a case review project regarding Intake Assessments, and use and completion of all data fields within the Intake Assessment. After a time, Consultant David Lloyd re-directed the SDT to address the more pressing issues of Concurrent Documentation and Clinical Formulation, in keeping with the above-stated goals. The SDT decided to conduct a pilot project addressing these two models and Jed Kovach, LCSW, Program Supervisor and Clinician for the agency's day treatment program was assigned the responsibility of leading the pilot project. (See Attachment A for "Pilot Team Recommendations to Quality Management Council").

Concurrent Documentation

According to a directive from the agency's management, the MWCMHC was beginning the process of adopting, learning and implementing the model of Concurrent Documentation (CD). This is a method of documenting the session content and process with the consumer at the same time the consumer is still present in the session with the service provider (The term "consumer" is used here to refer to an individual, couple or family constellation). Basically it involves incorporating an active discussion at the end of the service encounter and documenting the information provided in the Electronic Clinical Record (ECR), aka an Electronic Medical Record (EMR).

CD allows the service provider to confirm with the consumer in a proactive manner (a) the goals and objectives addressed during the session, (b) the therapeutic interventions provided by the service provider, and (c) consumer feedback regarding their progress and their perceived benefits of the service. In addition, this practice is an appropriate extension of the therapeutic interaction. It serves to focus the consumer on what just occurred in the service session as well as their next steps in the process of recovery and resiliency.

Perceived Benefits of Concurrent Documentation

To the Consumer:

- Involves the consumer in the therapeutic process and the recording of session content and process (this review promotes description, feedback, and insight).
- Empowers the consumer to know and determine the course of clinical assessment, interventions and progress of therapy.
- Real time feedback will increase the consumer's buy-in to services.
- Cutting out-of-session documentation time results in increased hours per clinician per year for direct service, thus serving more consumers and families.

To MWCMHC Staff:

- Because service providers will clarify their impressions and therapeutic interventions by putting them into words in front of the consumer, this enhances the therapeutic value of the service/session.
- Ensures greater content accuracy because of reduced time between the actual service and writing the progress note.
- Eliminates the staff's "treadmill" of always having to catch up on documentation of services, that is, to keep paperwork timely and accurate.
- Can save up to 8 hours per week (or 384 hours per year) in documentation time.
- With increased time availability, this allows service providers to be less anxious about accepting and seeing more consumers on their caseload at any one time.
- According to some studies, an organization's conversion to CD is accompanied by a drop of up to 25% in staff sick time usage
- Less anxiety and stress to direct service staff would result in enhanced morale greater job satisfaction, and improved quality of life and sense of well-being.

To the Agency:

- Sets a standard for clinical formulation among all staff to assure documentation completeness, consistency, and compliance with all applicable state, federal and accreditation standards.
- Increased documentation compliance would lower likelihood of paybacks via OIG audits
- Staff's increased availability could help service clients with other payer sources and/or a larger penetration rate of Medicaid clients.
- Increased staff morale and enhance quality of life would reduce staff burn-out and turnover rates.

Perceived Hurdles to Overcome to Successfully Implement Concurrent Documentation

- Integration with current (Qualifacts) or new Electronic Case Record (ECR)
- Consumer and staff anxiety and resistance to change
- Staff training needs
- Facilities adjustments
- Additional equipment
- Not lagging with follow-up and agency-wide implementation

Concurrent Documentation Pilot Project

During a six (6) week period from June 11- July 20, 2007, eleven (11) MWCMHC staff were selected, trained and participated in a pilot project. The staff represented a cross-section of positions at the agency - clinicians (individual and group), case managers and one medical prescriber (an APRN). This pilot project addressed the practices of Concurrent Documentation and a Clinical Formulation Model at the same time. In addition to the description of Concurrent Documentation noted above, the Clinical Formulation model was examined in an effort to establish a set of standard criteria that should be covered in Assessments and each Description-Assessment-Plan (DAP) progress note to achieve completion, consistency and compliance across the agency staff. The agency's goal is to ensure that the "Golden Thread" of medical necessity linkage is established and carried through in each consumer's ECR, both for accuracy's sake and to satisfy the increasingly stringent State and Federal requirements.

The training for this pilot occurred on June 7, 2007 and included pilot project participants, MWCMHC Program Supervisors, SDT members and members of the agency's management team. The training addressed the agency's adoption of this model, the nature and benefits of CD, introducing CD to consumers by means of a "script" inviting consumer participation, maintaining a positive attitude about this CD process, time usage, and some practical aspects of actually doing CD with consumers.

Each pilot project participant took stock of their offices and identified modest physical changes (furniture, longer computer cables, rearrangement of room configuration, etc.) that would enhance model adoption and usage during the pilot. The participants implemented these two models with their clients and client case files were monitored to examine the effects of these two models on practice. Pilot projects received positive support from both their Program Supervisors and the pilot project manager (this writer). Three peer support sessions were held on 6/24/07, 7/17/07 and 8/16/07 to discuss and refine the pilot project process as it evolved, and examine the pilot outcomes. Written feedback from both client and clinician was also obtained to evaluate how this process impacted client and service provider.

Written Feedback Results of Pilot Project

Each pilot participant was asked to have 3-4 consumers complete feedback forms at the beginning middle and end of the project. Unfortunately, the follow-through on this was fair and resulted in a sampling of only twelve (12) consumers. When asked to rate the process on a Likert scale, the following results were given:

1. Not Helpful - 0
2. Somewhat Helpful - 1
3. Neutral - 1
4. Helpful - 6
5. Very Helpful - 4

Consumer feedback to the question - "What was/was not helpful about Concurrent Documentation?"

- 6 consumers said reviewing of issues covered, goals and progress was helpful.
- "Knowing what changes my therapist notes."
- "To visually see what accomplishments I've made and what I am doing to achieve more of my sobriety goals."
- "My therapist has helped me reach my goals and go beyond. I am feeling so much better about myself and controlling my pain."
- "This was very good to work with my counselor in keeping my goals. I wouldn't change anything with this process."
- Client explained that she is processing information better and that she appreciates being a part of the process and knowing what goes on in her notes."
- "It's good to reinforce that we both recognize the key points of the session. And it's helpful to set goals to work on before the next appointment."
- "It's helpful to clarify thinking and goals and keep my mind on possibilities instead of limitations. I know the counselor and I are on the same page."
- "The time taken to complete the process."
- "As long as it doesn't take too much time from the session."

Consumer feedback to the statement - "If there was one thing I could change about this process, it would be…"

- "I don't know."
- "I do not have enough information yet (for this question)."
- "Nothing." - 5 consumers
- "Would not change anything with this process."
- "I'm satisfied with it."

Oral and written service provider feedback to the question - "What was/was not helpful about Concurrent Documentation?"

- "Prior to the study, I asked clients what they thought we worked on in the session. With CD, clients are more aware what content of the session is documented and they know that we agree on the session content/outcome."
- "It was helpful to use this process with a client and to have her feel like she had a greater say in the paperwork. And to get the paperwork done right then, and not have it build up."
- "It was quite difficult to do CD with my clients. Those that I did succeed at it with, CD seemed to help to recap the session and point out clearly to the client where the client was having difficulty. In some ways I do think CD could be useful."
- "Turning away from the client."
- "The thing that is weird is to try to still make the notes clinical while including the client in doing each part."
- "...it is just going to take some time to make changes...creature of habit...but I think this will be beneficial all the way around. I did like the suggestion of speaking to the client one week and maybe instituting the plan in the next session…less shock to both therapist and client."
- "I rarely see clients at home or in the community and not many places have WiFi in Nucla, Naturita, or Norwood. I can use Word instead in those situations. The one exception will be when I'm in the jail, because they don't even let me take in my keys let alone a laptop, I will just write my notes after leaving the jail."
- "We spoke on Monday about what set up would be most useful in the group settings for CD, and (one staff) had a good idea. Rather than a lap top which is cumbersome to actually hold and work on your lap, why not consider a regular computer with a flat screen and a wireless keyboard. I think they are called infra red keyboards. If the flat screen were large, say 17", it could also be used to show DVD and power point presentations. But with the wireless keyboard, we could stay in the group and still see the screen from across the room."

Of note, one therapist reported that she reduced her documentation time in the last month from a baseline of twenty (20) hours per month to thirteen (13) hours in the last month. This is in addition to the fact that this therapist does several groups per week (groups do not lend themselves easily to concurrent documentation - see later in report).

Oral and written service provider feedback to the statement - "If there was one thing I could change about this process, it would be…"

- "CD was not helpful in that I get a lot of my insight into the client and his/her behavior as I reflect when writing the Assessment part ("A" of the DAP Note). It is extremely difficult to do this while the client is sitting with me. This is the one area I would change: time to assess and write the assessment after the session, and perhaps discuss this with the client in the next session."
- "Changing the set-up of the office to allow me to look at the client while talking with them and writing the note."
- "Have an easier way to do CD while on the phone, which hopefully will be facilitated through the (telephone) headset."
- "Also having a good way to do CD in groups."

One therapist reported that he has difficulty with what to include in the Assessment section. He has many early recovery clients who employ the ego defenses of denial and minimization. When he attempted to share his mental status exam results with clients, they tended to become confrontational and argumentative. Two solutions posed to this therapist were (a) to use this encounter therapeutically and assist the client towards some awareness of what they doing, and (b) note in the DAP Note that their was a difference of observation and opinion between the service provider and the client, and to document each party's perspective. It is especially effective to use quotations for the client's comments.

Clinical Formulation

Along with all Community Behavioral Healthcare Organizations, this agency is facing more stringent federal and state standards, and our compliance with these external accountability requirements is becoming more demanding. Some of these standards relate to efforts to reduce fraud and abuse in healthcare and to prevent submission of false claims. In some cases, large sums of Medicaid funds are being recaptured from CBHO's when audits reveal that existing service documentation does not validate and support the medical necessity for services rendered and charged. As a recipient of annual Medicaid payments, the MWCMHC is working to ensure its compliance with federal and state laws and regulations related to the Deficit Reduction Act, False Claims Act, and Criminal Penalties for Acts Involving Federal Health Care Programs Act, and with any government initiatives to reduce healthcare fraud, waste, and abuse.

In response to these requirements, the agency also addressed the issue of Clinical Formulation and it was combined with the Concurrent Documentation model in the pilot project. While this model did not receive as much focus in the project, its importance was emphasized and pilot project participants were urged to examine and improve the quality of the note as well as the manner in which it was being completed (CD). This was an endeavor to establish a set list of standard criteria that should be covered in Assessments and each DAP progress note to achieve completion, consistency and compliance across the agency staff. The agency's goal is to ensure that the "Golden Thread" of medical necessity linkage is established and carried through in each consumer's ECR, both for accuracy's sake and to satisfy the increasingly stringent State and Federal requirements.

In addition, this writer developed the Intake Assessment, DAP Note and Service Plan Primer from several sources to assist pilot project participants (and eventually all agency staff) in this effort to improve documentation quality and compliance.

Agency-Wide Training

In August 2007, two successive "Question and Answer" articles on Concurrent Documentation by this writer were published in the agency's on-line newsletter, The Centerline. The intention was to "prime the pump" for agency staff in anticipation of the upcoming Concurrent Documentation training.

Subsequently, a mandatory agency-wide staff training session was held to introduce Concurrent Documentation and Clinical Formulation. This occurred on Thursday August 23, 2007 from 9:00 am – 3:00 pm. All Program Supervisors, clinicians and case managers were required to attend. Only prescribers were not required to attend. On the day of the training, 46 of a possible 48 staff were in attendance. The concurrent documentation session was held from 9:00 am to 12:00 pm by MHC therapists Teresa Thompson, MSW and Jed Kovach, LCSW. Lunch was served from 12:00 – 1:00 pm. The part of the training regarding clinical formulation was facilitated by Dr. Steve Dixon, Clinical Director for the Colorado Health Network from 1:00 – 3:00 pm.

During the CD training, all pilot project participants shared testimonials about their experiences (both positive and negative) with the pilot project. This generated a lot of discussion from both the pilot project participants and the other staff present. Training attendees were all given two written hand-outs: Concurrent Documentation Training Handbook and an Intake Assessment, DAP Note and Service Plan Primer. (Please see two Attachments). At this training, all staff were informed that concurrent documentation would be implemented agency-wide beginning Tuesday September 4, 2007.

Immediately following the training, this writer sent an email to thank all attendees for their attendance, to affirm them for their willingness to apply themselves to learning and implementing these two models, to remind them of the agency implementation date of September 4, and to encourage them to use four resources for support as CD is implemented: (1) The training hand-outs, (2) Program Supervisors, (3) Peer staff members, and (4) this writer as the CD Implementation Leader.

Recommendations

In an SPQM meeting on Monday August 20, 2007, consultant David Lloyd urged the agency management, supervisors and staff to view the shift to these two models as a ***process*** of change, not a ***single change event***. Seeing this as a process that must be "unfolded" can be encouraging in that it is not something we are going to do just once and then it will be "working."

In addition, Concurrent Documentation is not the end in itself. Rather it is a tool to achieve the greater goal or end of improving the timeliness of documentation submission. And Concurrent Documentation is the most effective tool to facilitate and achieve that goal; other tools might be improved time management skills, change of ECR software, and change of specific forms. The complicating factor here is that CD is not a tool/model that can be evenly and cleanly "plugged in" and then implemented across all therapists and their differing levels of clinical expertise, staff roles, and varied settings. One other cited factor was the types, diagnoses and temperaments of MHC consumers.

The recommendation is that in adopting concurrent documentation as a means of improving timeliness of documentation submission, and setting a standard for staff to practice this model, compliance with this goal needs to take the above variables into consideration and defined accordingly:

- Individual sessions – CD 100% of time
- Family – CD as much as possible, 100% of documentation is submitted by 12:00 pm the next day
- Group – when CD is not possible or infeasible, 100% of documentation is submitted by 12:00 pm the next day
- Case Management - CD as much as possible, 100% of documentation is submitted by 12:00 pm the next day

As mentioned above, timeliness is the essential goal and value here. It is important to convey the attitude that the practice of CD for the MHC is no longer a discussion or decision to be made. It is a tool to facilitate timeliness, and the agency is adopting and will be using this documentation model. The other question is not whether staff will use it or not. The question is how each staff can utilize Concurrent Documentation given their various and different roles and responsibilities to facilitate this timely submission of documentation.

Individual Therapy

During and after the pilot project, it was discovered that Concurrent Documentation worked well in service settings to individuals, particularly psych-therapy. Once individual therapists overcame their fears, reservations and anxieties, they were able to integrate this practice with minimum difficulty and nominal client resistance.

Challenges and Difficulties with Groups and Case Management

During and after the pilot project, two areas of challenge with CD emerged:

Case managers reported several challenges to practicing CD with their clients and various service provision settings. Many of the Case Managers found it difficult to do CD with some of their very chronic, low functioning clients. Case Managers reported that these clients are typically hyperactive and cannot sit still for 5 minutes, have difficulty focusing and paying attention for even the shortest periods of time, and lack even basic insight and judgment. Thus it has proved problematic to document even a 15 minute session concurrently with the client. Other clients exhibit severe paranoia, particularly with technology (as if the government or aliens are using technology to spy on them). One case manager noted that she was successful with CD with a few chronic clients. She reported that their success seemed to be determined by their rapport with the case manager, the diagnosis/diagnoses, the client's attitude and if they were involved with the Open Arms Empowerment Center.

Case Managers also reported challenges with various service provision settings. Sometimes they do work "on the run" in the field (in a car, hospital, jail, etc.). This movement makes it difficult to do pure concurrent documentation.

One possible solution is that each case manager be given laptop computers with wireless Internet capability. This may still prove problematic in areas that have poor or no Internet service. Where there is not Internet service, service providers can use Microsoft Word to draft a DAP note, transfer it to Qualifacts when it is available and then delete the DAP note from the laptop Word document (for the sake of confidentiality). Another possible answer is the use of an MP-3 type device that has voice recognition capacity and can later be transferred the data to computer as text. These solutions would certainly move us closer to CD in the area of case management but may prove to be cost prohibitive.

This challenge of conducting CD in case management was posed to consultant David Lloyd. In response he gave the following recommendation:

"In most cases, the CMs have found it helpful to use CD in the field if they are able to record electronically or if the MHC is using a paper record and the CM is able to write the not in the presence of the client/family. The use of lap tops or other portable recording devices has been very positive to help CMs to better manage their time. One suggestion would be to lease two or three used laptops from a office supply store (I purchases two laptops from a used office furniture store in Fayetteville, NC) to use as a pilot for two or three case managers that are willing to use this CD process. The key in this case is to confirm if the time gained in documentation via computer in the community positively impacts the direct service time the CMs can provide. If there is a positive cost versus benefit ratio, then it may be helpful to equip other CMs to ensure maximum direct service levels are being delivered in the community.

Another key in the community is encourage staff to use the "Do as much as you can" model where they document enough of the note (Interventions provided, response from client, etc.) with the client that they do not have to start from WHITE PAPER at the end of the day."

The second area of greatest challenge was attempting to practice CD with groups (this includes large, sometimes chaotic family units). We have discovered it is almost impossible to do concurrent documentation with each member of the group, especially if the group is 10-14 members. If you allowed even 3-4 minutes for each group member's note, that would consume 45-60 minutes of an hour and a half group. This would most likely affect the group content and the process away from clinical compliance standards.

When questioned, the Program Supervisor for the Substance Abuse Program wrote,

"I think concurrent documentation works reasonably well with groups of six or less clients. I am still concerned that with our larger groups concurrent documentation will cut into group time substantially. I know there has been discussion of the clinician marking the group roster and having the group participate in writing the session content then writing DAP notes from paper prompts completed by each client before they leave the group. I think this makes more sense for larger groups."

Several group facilitators had tried this method of using a brief handout toward the end of each group. With this tool, each client completes several brief questions about that specific session, take some time to discuss it as a group, and the facilitator then does the notes after the session based on the member's handouts/discussion. Indeed the group therapist in Gunnison had already been using this format, even before the CD pilot project. Two other group therapists began to use this model and found it to be more effective than using nothing. While this is not "pure" CD, it is moving closer to the model and has the potential to improve timely submission of group documentation.

The other suggestion to group clinicians was to end the group 5 minutes early, select one group member each week and do CD with that one client. At the next group, the clinician would choose a different client for CD. This would continue on a rotating basis. While this would not cover all clients for each group, it would provide each client with the experience of actual CD.

Concurrent documentation may be more feasible with groups with smaller numbers (5 or under) and those that follow a set curriculum, like DBT and DUI groups. However, the process oriented group members have individual service plans and goals that they are working on and the DAP notes must link to the golden thread. This makes it more challenging to provide concurrent documentation for the Assessment and Plan section of a DAP note.

This challenge of conducting CD in groups was posed to consultant David Lloyd. In response he gave the following recommendation:

"**A key to CD in group settings is to ask staff to use the "Do as much as you can" model where they document at the end of the group session at least the client's response to the interventions provided. This can be accomplished in much less time by keying in the responses on each of the opened EMR progress notes for each group participant. This process will allow the provider to conclude the group and then complete the remainder of the not for each attendee before moving on to the next activity (good time management model). Also, as staff had used this model, they find that they can expand the documentation to:**

1. Pre-Group Documentation: Open a note for each participant, pre-complete the date, time, group topic/interaction that will be provided, service code, group name, client ID, staff ID, etc., so that this information does not have to be populated after the session.

2. In-Group Documentation: Clients response, number of goal and objective that the group interaction addresses for each individual client in group.

3. Post-Group Documentation: Complete Interventions provided section of the note linked to the group topic/interaction and complete the plan for each client.

This model requires that staff really look at time management principles before, during and after the group (same applies for individual modality work as well).

The only challenge here is that opening up each chart before the group begins is not feasible with Qualifacts. This indicates that the client has kept his/her group appointment in advance, not knowing if the client will truly show up to attend the group.

In conclusion, as CD is rolled out to these areas of the agency, we will most likely have to adopt an evolutionary perspective, that is, these areas will have to undergo a choppy beginning and evolve through some trial and error process. As this occurs, hopefully the best practices of CD in these last two areas will slowly but surely percolate to the surface for adoption and use.

Psychiatrists and Other Precribers

The one area where the pilot project fell short was instituting CD with the agency's psychiatrists and other medical prescribers. An APRN was included in the pilot project and was able to practice CD in some sessions. She was doubly challenged in that she was also learning to use her new voice recognition software at the same time. She reported that she found it particularly difficult to do CD when she was conducting a full psychiatric exam. The agency will need to take further steps to introduce, train and implement CD with psychiatrists and other medical prescribers. Some of these staff have already has been practicing one form of CD by using dictation after the session and then notes are transcribed into the ECR at a later time.

Technology

Another general recommendation has to do with information technology. To keep pace with the needs to practice CD agency-wide, the agency may need to make further investments in advancing this technology. This may include more telephone headsets and laptop computers, stationary and portable voice recognition systems, and making typing tutorials available to staff (IT recommends the Mavis Beacon software which is relatively inexpensive but efficient). If the agency upgrades to Qualifacts 5.0 or selects a new ECR software, this may improve and enhance the ease the practicing CD.

Keeping the practice of CD alive in the agency:

The pilot project leader requested referrals from David Lloyd of other agencies who introduced, adopted, provided training and subsequently implemented CD. One contact was an agency that provided mental health services to a county in Illinois. The contact noted that 4 years ago their agency had attempted to do this but met with limited use and success. They are trying a second go-round to refine the adoption process and make CD the standard of practice throughout their agency.

From this discussion it can be concluded that at least one agency's tendency was to "drop the ball." Hence the introduction, adoption and implementation of the CD model must be followed by ongoing/continuous training, monitoring, reinforcement and validation. This part of the process is imperative so that the practice of CD at the MWCMHC does not fizzle and die out in sectors of the agency. One means to accomplish this is through ongoing staff monitoring and support.

Program Supervisors can use their staff meetings and supervisory sessions with staff to train, encourage and monitor the implementation process with each staff. Program supervisors can continue to enumerate various benefits of CD to the consumer, service provider and agency (See earlier in report).

Shaun Sowle, Program Supervisor at the Miami Office creatively used CD during her supervision sessions with staff. Shaun would employ CD to record the content and process of the supervision session in real time. One benefit is that Shaun was able to complete her documentation and not face a back-log of supervision documentation. Another benefit of doing CD with the supervision logs is that it allows staff to be on the "other side of the fence" and experience what it is like for the client to use CD.

The pilot project leader submitted two brief articles on CD for publication in The Centerline newsletter in advance of the agency-wide training and roll-out. This newsletter could be used as a vehicle to keep the practice of CD in front of staff, perhaps featuring case studies, staff feedback, new developments with CD, etc. Or to ensure that staff would be more likely to read it, this information could be emailed to all staff on a periodic basis.

This practice along with other results of the MWCMHC Change Initiative (centralized scheduling, productivity standards, job descriptions and performance evaluations, and the new no-show policy) could be briefly addressed and reinforced in the agency's All Staff meetings.

It would also behoove the agency to stay abreast of any advances in CD in the field. David Lloyd is most likely the best resource for this course of action.

Client Introduction and Reinforcement:

As was noted before, the majority of the small sample of consumers polled indicated positive attitudes toward the practice of CD. Lower functioning consumers, especially those with paranoid and/or hyperactive, ADHD-like symptoms, would most likely put up an ongoing battle. However, many consumers will have initial anxieties and related tendencies to deny or resist the practice of the Concurrent Documentation. Thus the way in which service providers' introduce CD to consumers becomes crucial to how consumers will accept it. Staff have been taught to develop (a) a script for what to say with initially introducing the concept and (b) a cue or statement to move toward CD in each subsequent service delivery session. As clients become more used to CD, staff may have to become more directive during the session and ask the client to hold their thoughts at times until the documentation is complete.

Many consumers also welcome the opportunity to be more involved in their treatment, particularly with what is documented in their charts. As also noted by some pilot project participants, many of the clients actually reminded the service provider that it was nearing the time in the session to do CD. Many pilot project participants reported that they began to the service session by reviewing the DAP note from the last session. One advantage the client remembers what was written from the previous session, and both service provider and consumer have some basis for "launching" the session. This can assist in continuing to establish medical necessity for treatment, and to ensure treatment continuity overall.

It has also been proven that CD promotes improved time management in a session. These parameters make time constraints more apparent and clients seem to be utilizing their therapy time more judiciously. There do seem to be some client's that are motivated by this in their therapy, and some client's that show a bit of anxiety due to the different time line. However, in the end, the client's appear to be adapting well. While this was not demonstrated in the MWCMHC's Concurrent Documentation pilot project, it is reasonable to anticipate a similar outcome.