>> Hello, everyone, and welcome to today's webinar on the progress note where law and ethics meet efficiency, presented by Beth Elizabeth Irias. It is great you can join us today. My name is Samson, and I'm the director of training and professional development for NAADAC, the association for addiction professionals. I'll be organizer for this training experience. In an effort to continue the clinical professional and business development for the addition professional, NAADAC is fortunate to welcome webinar sponsors, as our field continues to grow and responsibilities evolve, it is important to stay informed of best practices and resources supporting the addition profession. So this webinar is supported by ICANNotes, the most clinically who want to reduce their documentation time, minimize legal risk and code at the maximum level of reimbursement. The permanent homepage for NAADAC webinars is www.NAADAC.org/webinars. Make sure to book page this webpage so you can stay up to date in addiction education.

Closed captioning is provided by caption Being a he is. Please check your most recent confirmation e-mail or our Q & A and chat box for the link to use closed captioning. We're using GoToWebinar for today's live event. You'll notice the one that looks just like my slide here. Here are some important instructions. You have ender in to what is called listen-only mode that. Means your mic is automatically muted to prevent any disruptive background noise. If you have trouble hearing the presenter for any reason, consider switching to a telephone line use willing the audio option. You can use that orange arrow anyplace time to minimize or maximize the control panel. Also, if you
have any questions for the presenter, just type them in to the questions box. We'll gather the questions and I'll pose them to the presenter during our live Q & A. Any questions that we don't get to we'll collect directly from the presenter and post those questions and answers on our website.

Lastly, in the webinar control panel, right under either the audio icon and in the questions box, you will see one more box called handouts. In that tab you will see a handout from the presenter, handout from the sponsor, and a copy of the slides, three slides per page in PDF form.

Now let me introduce you to today's presenter, Elizabeth Beth Irias is a California licensed marriage and family therapist, the founder and president of clearly clinical, a national podcast based on-line behavioral health continuing education program that is also a certified continuing education provider by NAADAC. She is known as the utilization guru and she has clinical documentation and works closely with clinical teams across the country to reduce liability risks and improve quality of care documentation practices and utilization outcomes. As an adjunct at Pepperdine university, she is an engaging conference speaker. She also operates a private practice where she provides therapy to adolescent and young adult clients, LGBTQ population and those with addictive disorders.

NAADAC is delighted to provide this webinar to you by this accomplished trainer, and NAADAC continuing education provider. So Beth, if you're ready, I'll hand this over to you.

>> Wonderful. Thank you so much, and thank you to ICANotes for sponsoring today. Hello everyone out there, my name is Beth and I'm a licensed marriage and family therapist and I know that our world is very weird right now and we are all very focussed on a few words that do not include clinical documentation so thank you for joining us. It is a welcome break for me to be talking about this because so much what we've been talking about is pandemic or Coronavirus or any other terrifying words and for some of you the clinical documentation might also be terrifying but hopefully it will feel better after today's training.

So Samson and I have been going through the timing. Because of the influx of users that are working from home, the timing on the slides is a little bit delayed, so please bear with me on that.

Today we are going to be talking about a few things. By the end of today's webinar, you should be able to list three legal and ethical implications of an adequate clinical documentation. You should be able to identify five important components of quality clinical documentation as they relate to best practice, and also provide a general definition of medical necessity.

So today we're going to cover a whole lot of information. Sometimes when I do the same training I can honestly fill three or four hours, so I'm going to be going pretty rapidly. And also I'm hoping to have the opportunity at the end of this with Samson to answer some of your questions.

So he let's start by asking a question. Have you ever been told - sorry, we skipped a slide there. Let me hold that. We're going to hold off on the question right now. I want to start by telling you a little bit about how I see it. So I have been doing utilization review for well over a decade, both in medical and in behavioral health, and for those of you who don't know utilization review is a process through which insurance providers
grant approval for services. And basically all of us have been involved in utilization review one way or another. For ourselves, for our kids, for our family members needing to get any kind of service. And for me, in particular, I have two children and one of them has a major medical condition that has required a whole lot of testing and has cost a great deal. And because of really the process of utilization review and the establishment of medical necessity, we've been able to use our insurance benefits to cover that.

As many of you know joining us today, some of you may work in facilities or in private practice, so you are constantly vying with insurance companies for insurance authorizations using medical necessity, and you've probably seen first hand how difficult it can be sometimes to get this authorizations. And just to shout out to those of you who don't accept insurance, today is still totally relevant but so going back to my why, for me, this is personal, I think for all of us it is personal when it comes to advocacy for medical and behavioral healthcare. And as you know, we have care access issues, particularly for behavioral healthcare and sometimes it is our notes that can either help somebody get the care they need or prevent them from getting that care.

As I mentioned, I come from the world of medical first and worked for a surgeon for a number of years and I adhere to something called a medical model of as therapists and counselors, we sometimes forget that we're really part of the medical field and I'm going to be giving you some examples today, looking at things through the lens of what if a doctor did it this way and I think it helps clarify some of our decisionmaking because I know there are a lot of myths that float around about clinical documentation.

And last but not least, the only way that I know to make sure or at least try to not let your heads hit the keyboard because you've got painfully board talking about clinical documentation is to crack jokes. It is not because I'm making light of the seriousness of what we're talking about today but because number one it is my personality and number two, it is the only way I know how to make this interesting. So bear with me. Thank you for joining us today. I know this is such a bizarre and heavy time. It is for me too, and I can feel you out there and I'm happy to spend this time with you. So let's dive on into it. Okay. So we're having a bit of a delay with the slides so bear with me. Stay with me, guys. I'm sorry it is taking so long.

Okay. So let's start with a question. Have you ever been told by someone, maybe your professor or a supervisor, that you should keep your progress notes short and vague? So please take a moment to answer this question. A, yes, I've been told that. Or B, I have never been told that. So take a few seconds.

>> Excellent. Thank you so much. We just launched that poll on the screen. You will see it pop up with the options, it looks like half of you have voted already, so I guess you're used to this. We'll give you about ten more seconds to interact with that poll. Great. Thank you so much, everyone. I'm going to go ahead and close this poll now. We got 75% -- 78% in now. I'll close the poll, share the results, and turn this back over to Beth.

>> Okay. So we have about two-thirds of you that have been told that. So I was too. My clinical supervisor who is actually now a deer friend of mine, worked with him for years, one of the very first thing he it told me is I needed to keep my progress notes short and vague. He worked with primarily families that were going through the mediation process in court in so in his mind notes were there to really protect a client's
privacy and confidentiality. So today worry going to be talking about that that and I'm going to give you some information for the 68% of you that were told that, it is not actually the best advice and I'll tell you why. We'll talk about novel writing and there are benefits to not writing super long notes but we actually open ourselves up to a lot of liability risk when is we are making our notes short and vague I even was told by someone to make nine notes illegible and that would be another way to protect myself or protect my clients. But the truth of the matter is that actually leaves us wide open for liability risks.

So when we're talking about clinical records, I wants you to go back to those five Ws that you learned when you were much younger when, you were writing a story, and our notes need to have the same things, the who, what, where, why, and when. We are pretty good at capturing four of these. There is one of these, the when, or excuse me, the why, that we are not so good at getting. What I mean by that, we are not add goods as describing for someone for a reader of our documentation why we diagnosed a client a certain way or why we’re recommending a certain kind of treatment or why we used a certain intervention or why we referred them to a higher or a lower level of care. I want you to keep in mind the why, because really and truly the why is what underlies our records and is the backbone of necessity.

One other thing to point out, we use the phrase client chart liberally. That's what we call it, grab the client’s chart, go into the client's chart in the electronic health record but in this doing this, it is a misnomer that makes us feel like our records are totally the property of the client. In most states, our records are actually our property or the facility where we work and why I bring this up is because our records are as much for us as they are for the client. And, in fact, most states have some kind of restriction as to what clients can access in their own charts, short of a court order. I'm out here in California and short of a court order, we basically have the right to limit a client's access to their charts under certain circumstances and can release a summary instead. We’ll talk about this a little bit more. But I want to point this part out because I know my old supervisor said, it is the client's private information and we should write as little of it as possible in the node to protect them, you know, what if they end up going to court or there's a custody battle. And going back to that medical model, imagine a doctor not writing certain things about the appointment that they had with you because they were trying to protect you. So imagine seeing a doctor and you told them, you know, some behavior that you had been engaging in that maybe was risky or was gross or who knows what it was but they didn't write it. They would definitely be stepping outside of best practice at this point and we would be doing exactly the same as therapists. I know sometimes clients might ask you to withhold information from a client's chart. Really in no circumstance should you be doing that. Our records always need to tell the who, where, why, and when, even if a client is opposed to that. And there are some cases where I mean, I've even showed clients my chart and I have said, hey, this is what I'm writing you, if you're curious, I'm writing you mindfulness activity and psycho education in order to build incite and then they can see, I'm not sitting there writing these really judgmental statements.

A quick note, make sure to know your states State's requirements relating to documentation of sensitive information. So certain states have guidance and limitations for things like HIV status or for addition status. So wherever you are, whether you're
private practitioner or you're working with a facility, your company, make sure to know this information. And moving away from this, I want to start kind of working towards a paradigm shift which I know is just a little teeny-tiny goal but the paradigm shift I'm really after is this. When we have quality clinical documentation, that leads to us have more financial stability, including liability reduction and don't worry I talk about this. It also gives us increased clinical reflex and responsiveness as well as improvements in those utilization review authorizations. Sorry I accidentally clicked and forgot to do the slide. When we have all of these things, we can achieve improved client care. When I say paradigm shift, I know, for me, I hated writing notes. So tell you a little about myself. I'm a licensed family and marriage therapist with a specialization in addiction and I know many of you are addiction counselors and work in the field of addiction and my first really boots on the ground internship, I basically was handed keys of my training, I was working with high acute youth with severe substance I think so addiction and mental health disorders and my notes I really had no idea what to write and I kind of thought that if I wrote really long notes I was bound to do it right, like I was perhaps, you know, I'd rather have too much information than not enough and very quickly I burned myself out. And you may be in that boat, you may be sitting there nodding at your computer or phone right now. And really everything that I'm teaching you started with a very self serving motive which was to make my life easier because I was so burnt out by clinical documentation and then the light bulb went off in my mind and I was like oh, wow, I used to work in medical and I know about medical records, why haven't I applied that to clinical documentation?

So what I'm going to be training you today is based out of all of that research I did and continue to do to help educate us. Because many of us didn't get training on this or if it we did, it is something that was said in one or two classes is usually what I hear from people.

So what I realized when I did this makeover for myself, when I was actively involved with my charts and instead of hating them at the end of the day, if I took them as an opportunity to sit there with my hands on the keyboard and think about what I did and why I did it, I actually became a better therapist. And what is really interesting is we have the research that's coming out of the International center of excellence Dr. Miller, Dr. Chao, Dr. Warring man, really incredible researchers that are showing basically the more responsive a clinician is, the better their quality of care. So I see our documentation as an opportunity for us to actually become better clinicians, not worse, because I know that many of you, if not of most you, totally hate doing your notes. And for the record, I don't like them either. I have yet to meet anybody that really does. But I have a much different relationship with them when I use it as an opportunity to help solidify the things that I did and why I did them.

So, again, when we have high quality clinical documentation not only are we potentially a better provider, we have more financial stability because our liability is reduced and some other things and we also have improved utilization review outcomes and all of these things make us better providers overall and the client care goes up.

So moving on to our next topic, parts of today's training are a little bit dryer than others. I put this at the front so that you don't look like that lady who is asleep at her desk. So right now we're going to be talking about some ethical codes. I'm going to go through
these pretty quickly, but I show them to you as an example of what is out there so you have some information to kind of inform your decision making.

So let's start at a really obvious place which is the NAADAC code of ethics which says that addiction professionals and other service providers, create, maintain, protect, and store documentation required by federal and state laws and rules and organizational policies. So here's the thing about notes. Substance abuse treatment counselors actually have better training in clinical documentation than oftentimes therapists and social workers do and one of the interesting things, I know many of you may be part of NAADAC but you also might be part of your state-based association that's your collective group you that follow for law and ethics, what's really interesting about this rule is that it tells you that you should create and maintain documentation per federal and state laws, rules and organizational policies but it doesn't really tell you what that means. So as we go through these other laws and ethics, I want to point out them here.

So I'm pulling from the APA for any of you who are psychologists out there, the American psychological association says that psychologists keep records in order to provide good care, assist collaborating professionals and share con any do you of professional services, provide for -- excuse me -- supervision or training, provide documentation required for reimbursement or required administratively under contracts or laws, document any decision making, especially in high risk situations, and allow the psychologist to effectively answer a legal or regulatory complaint.

So when we look at the APA we get a little bit more guidance as to why we're doing it but we also still don't get a ton of guidance about what needs to be in it. So as we keep looking at this, the way that I think about this, we basically have these professional organization that is are saying to us, you need to follow the speed limit and APA is saying you need to follow the speed limit because it is best practice, because there might be a legal or regulatory complaint bogs you need to document your clinical decision making if someone else looks at your charts but it doesn't actually tell what you the proverbial speed limit is and that's probably why you're here today because you're like, okay, they've told me to follow the speed limit but I don't know what it is. For those of you who are part of the ACA, the American Counseling Association, they note counselors should include sufficient and timely documentation to facilitate the delivery and continuity of services. They take reasonable steps to ensure that documentation accurately reflects client progress and services provided.

What I want to point out here with the ACA is the note of the word timely. So part of what we come in here to as professionals we work with really high risk clients a lot of the time. I know many of are you addiction providers and stuff goes very, very fast. As I say, the kitchen can get really hot really fast. And clients can go from stable to crisis state rapidly and obviously the priority is not going to be clinical documentation, your priority is going to be documentation. But the difficulty we nays and many of you may be nodding right now, we get behind in our notes and then we come to work the next day and then we have another thing happen and the next thing you know, two or three weeks have passed and we're behind not just on those notes from two or three weeks ago but all of the notes leading up to now and then we stop being able to sleep at night.

The reason, and by the way, you're not the only ones that get behind on notes. My husband is also a MFT and he, not too long ago, I plain I was behind on n
of course he chuckled to himself and was like, the pot calling the kettle black because I'm just as guilty of it as you are.

But when we're talking about the ACA, note that word timely. So it is not just that we do it and we include sufficient detail, whatever that means. It means that we do it in a reasonable amount of time so that there is an accurate reflection. Also pulling from AAMFT, so the American Association of Marriage and family therapy, they say marriage and family therapists maintain accurate and adequate clinical and financial records in accordance with applicable law.

So you're probably noticing a theme here, where a couple of these have talked about law, what law are we supposed to be looking a at? And I know there's a point where we get confused, and we'll come back to that.

So this is NASW, this is the national association of social workers which says social workers should take reasonable steps to ensure that documentation and electronic and paper records is accurate and reflects the services provide and that it should be, note the phrase again, sufficient and timely to facilitate the delivery of services and ensure con any do you of service provided to clients in the future.

So when we look at all of these different codes of ethics, we get all of the information that tells us here's what we need to be doing, I should say, here's why we need to be doing and then there's a bit of guidance, it needs to be timely, it needs to be sufficient but then we don't really define it. That's where we have to start looking at state laws and state ethical codes so it is important for you to inquire with your professional association about the state's ethical codes and laws. And I'll tell you something here. So like I said, I'm out in California and I have been, gosh, I've been a licensed MFT I think for over five years and have had internship before that, so probably almost a decade now. And I honestly had no idea that there were any laws about clinical documentation until well after graduation. And I think I may already actually have been starting the licensure process, I mean, I was already treating patients and clients but I was in the licensure process I think had applied to take my exam and it dawned on me somehow that maybe there are actual laws about this. Sometimes there are and I want to point you to the professional association to ask for clarification about the laws.

And I want to show you one here from California. So this is pulling from California health and safety code. Which says that a summary and remember how I said in some states you can release a summary of a record. We do that because there may be things in a record that we don't necessarily want a client to see or a parent or a caregiver or a loved one because we think it may be detrimental. Again, this doesn't apply for a court order but in California we have the right to give a summary of the record. And this is a law that we would actually be looking at to tell us what needs to be in our charts. So that would include the chief complaint, including pertinent history, any findings from consultations and referrals with other healthcare providers, the diagnosis, the treatment plan, progress of the treatment, prognosis, including significant continuing problems or conditions, pertinent reports of diagnostic tests, so particularly for you psychologists out there, and discharge summaries.

So California state law here is actually pretty specific, and when I've spoken to multiple attorneys out in California I've had, and I should note, I've had the pleasure of working with attorneys all over the country to learn more about not only kind of state
expectations but also federal expectations and that nebulous term standard of care, this is the law in California that they would point to. So if we were to get a board complaint here and it had something to do with our clinical documentation, they would probably pull out this law and say, basically, this is saying if you're going to write a summary, if you're going to do the cliff notes, as I call it, of a chart and, and there are probably here that have no idea of what cliff notes are, so when I was in school, when I was a kid, cliff notes were the things that you could buy to pretend that you read the book you that didn't read but you needed to do a book report on it and there was a shortened, condensed version, it was a summary of a book. So the law here was saying here's what needs to be in your cliff notes and then logically from that we need to assume, therefore, that is what must be in the chart. So if our summary is going to give the chief complaint and findings and referrals, diagnosis, progress, prognosis, our chart has to be tell that story, it has to be that book that the cliff notes are based on. So this is a law in California. I really encourage you to go back to your state professional association and ask them what laws would you be using to assess my clinical documentation.

And as we also look at this through the lens of accrediting bodies, some of you work for companies that are accredited by people like car for the Joint Commission. The both of those bodies don't actually specify exactly what needs to be in the clinical documentation but today the quality and content may well treatment is deemed appropriate and level of care is justified and reimbursable.

For any of you Joint Commission and review process you know number one, it is not fun and number two, you don't want to fail that review and have a corrective action because it often is related to clinical documentation. I should also note the clinical documentation guide that the Joint Commission came out with I think in 2018 is very good and it is a good primer for a facilities to take a look at of what the expectations are, coming from Joint Commission. I know some of are you not subject to that but just throwing it out there.

So let's talk about the consequences of inadequate clinical documentation. I just took a moment to kind of lull you into sleep and now I'm going to make your faces do this because this is where we talk about the -- we didn't talk about the good but just the bad and the ugly and this is why we're doing what we're doing and having this conversation today.

So many of you have heard this phrase before. If it is not in the chart, then it didn't happen. So it is true. Many of you are also probably using electronic records. I'm guessing most of you on some level have been having a conversation about telemedicine given what's been happening the last few weeks in our country or making that leap so you're probably going to be working in electronic records somehow. We may also exchange e-mails with one another, oh, my goodness, I see this to facilities all the time that someone might write what is a really a HIPAA compliant e-mail that is working through a secure server from one staff member to another but it outlines this thing in detail that happened with the client's mother in the hallway but it never makes it into the chart. When it comes to an investigation by an insurance company what we call an SIU, a special investigate -- excuse me, investigation unit, when it comes to that type of investigation, they're looking at the record, not what's in your e-mail, not your text messages, not even your voice mails, and if there were ever something to -- something
significant that happened, that called your clinical questioning or clinical reasoning in to question, it would leave you wide open for liability if it is not in the chart, and there are times that had this has become frighteningly pertinent.

There was one facility, and I warned you, I warned you that I was going to scare you, and I want to note these things are rare but I think they're important to hear. So I was working at a facility and we had what we called crisis therapists that would work later shifts and would go see the clients if they were in crisis and it was residential facilities, it was a very high level of care and high acuity, and we were supposed to write the notes before we went home but the truth of the matter is on those days we had been there since noon, we might be going home at two in the morning and sometimes notes just didn't get written. So one day a colleague saw a client that was in crisis and I know this colleague, amazing therapist, and the colleague went home after the client was stabilized, the client backed the unit, and went home and went to bed, pretty reasonably. That night, the client died by suicide. So I know that these things are very, very rare but in that case there was no record in the chart in a that clinician had seen that client, and the truth is that somewhere between 25 and 40 of us will have a client die by suicide during our career, I'm sure there are many here listening that today that have already unfortunately found themselves in that situation. We inherently assume a lot of risk in our careers doing what we do. And it is really important that we keep our charts up to date and thorough enough because unfortunately we never know what's going to happen. And, again, I know I'm scaring you and, again, these things, like, something happening with a client and it not being in the chart, it is probably pretty rare, but it is just like a car insurance policy. The probability of us getting in to an accident on our way home is not very high but we still have car insurance in order to protect ourselves in case we do. So just remember that if it is not in the chart, it didn't happen. Let's jump to utilization review and disability benefits. So our records it impact a client's ability to receive things like insurance authorizations and I also want to point out disability coverage. So those of you who don't accept insurance, you're like oh, utilization review, not really a thing for me. You're right. It's not. But disability is a thing that actually affects all of us and is one of our rights as an American. And one of our difficulties here, there have been cases in the United States where people have lost their disability benefits because of inadequate records by their treating clinicians. So there was one example where a psychiatrist had signed off for a women's disability a number of months because she had really severe disability depression and there was an investigation by the state and when they requested the physician's records in it, the doctor had copied and pasted so much information that they actually threw out the record and said that they couldn't use it as proof of disability and they forced the woman to repay pretty much every dollar of disability that she had received. So even if your client doesn't use their insurance to see you, we still have an obligation to them to document things in a I with a that support really not only their needs but what actually happened in the session.

So this physician when he was cutting corners probably was not really thinking about the fact that there could be an audit and if it is not this the chart, it didn't happen, and that it could establish medical necessity. Yes, there were subsequent consequences for that physician but imagine the consequences for that poor lady and going back to the idea of how I see it. Imagine if that were us. And if we applied for
something like that in our time of need and we weren't able to get our benefits because of notes. I mean, it shouldn't be this way but it is this way so we have to work within the system. And I also want to point out, what do your notes say about the quality of your work?

Many, many of us work in facilities, and notes and charts are changing hands all the time. So I used to run an admissions department for a large facility and I would get records from psychiatric hospitals pretty much daily, and once I got this chart about a young person that had been hospitalized and it was literally copies of the doctor's prescription pad. So I couldn't -- I mean, you know how doctors write. I couldn't even read number one, what was on the prescription pad. But all that it was the face sheet for the fax and a couple of prescription pads that had been copied.

And a few days later, I got a record from a different psychiatric hospital which I should note was UCLA so I'm not going to say the first one but the second one that was beautiful was UCLA and this thing, and I know I'm a total clinical documentation nerd, but this thing kind of made my mouth water because I totally knew what was happening with the client, I knew what their symptoms were, I knew what led to admission, I knew what their discharge status was, what medication they were taking, what their response was, how family involvement had been, what the systemic factors, were contributing to the person's care and when I think about those two records, perfectly bluntly, there's no way I'm going to refer to the first one. Because I can't assume their quality of care is very good if their clinical documentation is that poor.

But the second one for UCLA, it was so thorough and it was so clear that I just assume, hey, these people really most know what they're doing. So remember that your notes, wherever they go, they're telling a story but and they're telling a story about your facility and many of us rely on referrals to keep our doors open. So keep that this mind that we don't really know where our charts are going to go. I know I got your attention there. The F word. Not the fun one. Let's talk about fraud. So healthcare fraud is a type of white collar crime that involves the filing of dishonest healthcare claims in order to turn a profit. So we know what fraud is. We've all seen those pictures of different facilities that have had the FBI come and take their computers out down from the stairs from that facilities. It is often because they're fraud, it doesn't have to be intentional to be criminal. So we could be accidentally committing fraud without meaning to and it would still be considered a crime.

So let's look at some red flags. Copied and pasted phrases or sections, freak revisions to entries, missing entries, service overlap and inaccurate charting. So let's take a quick home to talk about copying and pasting. It is not that copying and pasting is inherently bad because let's be honest, we probably do most of the same things in each assessment session that we do. However, what's happened is people have gotten too liberal with their copying and pasting and like that disability example I gave you, the reason that the -- it was clear that the doctor had copied and pasted, he had misspelled two words that kept recurring as those misspellings in multiple senses in duplicate notes.

This has happened, I can't speak for other states, this has happened all over California, this copying and pasting. There are programs that specifically go through charts to look at copying and pasted phrases or sections just like the programs that I
used at Pepperdine to see if my students were copying anything out of other texts and were plagiarizing. So keep in mind if they're copying and pasting, it should be done extremely rarely. And only when it is specifically applicable to that particular client and generally it's a no-no. Generally it is frowned upon and I don't recommend it.

Regarding frequent revisions to entries, we should really only be doing this if it is something super important. So if is it is five days later and you're reading a note and you realize you've misspelled a client's name. It's cool. Leave it. It is not that big of a deal. It is not worth modifying the record. If we go back and modify a record, it basically impacts the integrity of the record and it makes it look like we are not reliable. So it is not that you can't revise records, we have an ability to do electronic health records because sometimes we just need to but I remember when I was an intern, like if I misspelled something, I would flag it and like send a message to my supervisor and be like oh, I need to revise it, not understanding that it was impacting the integrity of that chart and it really wasn't worth it because I had misspelled a name or something like that.

Missing entries. So your facility or maybe you as an individual, if you have prior practice, when you bill insurance, you're saying, yes, this person had two hours of group today and one hour of let's say case management and an hour of individual therapy. If there aren't notes to back up that what you did during those sessions, you committed fraud, you're already submitted the billing and those notes aren't there because maybe you're like oh, I'm behind in charting, it will be fine. But imagine if the insurance company or anybody for that matter audited and there wasn't a note associated with that service. That would be fraud. Service overlap. So unless you're an Olson twin, you cannot be two places at once and nor can your clients. Where this comes up, and this happens a lot sometimes in facilities, have you a client in a group and the psychiatrist knocks on the door quietly, points at someone and does the come hither finger and is like come here, and takes them for a psychiatric appointment but now you have a client that is two places at once if you don't chart it appropriately. So you have one note saying the client was in group and you have another note saying the client was in psychiatry. Now you've just committed fraud as well. So you need to be very careful about those kinds of things.

And, in general, inaccurate charting. Do not report things that didn't happen. Do not say that the client was there for longer they were. There was a case in California where a kiddo had been coming in for therapy and I guess the kiddo was tired because our academic system is so rigorous, and the child was sleeping on the therapist's couch and the clinician was writing all of the things that he had planned to do with that client during that time but the kiddo was asleep. The child ended up telling the parent and saying, you know, the parent I'm sure asked like many of us, how is it going in therapy and the kid was eventually like I don't know, I've been sleeping, it is good, he has a comfortable couch. Needless to say, the clinician was investigated, lost their license and also lost their job. Inaccurate charting. Don't do it. So really at all costs, avoid the F word because it is just not worth it.

So the other thing I want to bring up, unforeseen circumstances. What happens if you abruptly leave your practice and your records are disorganized? So many of us are required to complete a professional will and we do this so the people behind us can see what we've done and why. We don't know when something is going to happen and let's
be honest, even right now people are getting sick right and left and they may abruptly leave their work in which case a colleague is probably going to step in and cover for them. It is really important that our records tell the story of what we did so that the person is that in behind us or alongside us can figure out what was going on because if we were looking at the medical model, imagine a doctor not documenting certain treatments that they had delivered, certain things that they had prescribed, for example, and then another doctor comes in, looks at that chart, gives them no information and that doctor could unknowingly duplicate treatments that have already been infective for that patient. We don't want to have our clients in that particular situation so it is important that your records are legible and organized.

How good is your memory? So in California our records need to be on, in general, we need to keep them for seven years. Or seven years past the age of majority. So if we see a client when they're ten, we need to actually old on to their records for 15 years because when they turn 18, we need to hold them for another seven years.

So here's one of the things about California can be filed with the California behavioral sciences ten years after the service occurred. Our memories are not very good. I know this because every once in awhile I end up with a milk on the top of my washing machine and the soap for the washing machine in my refrigerator. So many times we'll say to ourselves, like oh, I'll document that conversation with psychiatrists and we don't do it. Our memories are extremely poor and especially after years and years and years, they get remarkably bad, so keep in mind, your memory isn't very good and your records could be called on anywhere from seven to potentially 25 years after you saw somebody the first time if you were seeing, you know, a little tiny kids. So just keep in mind that they need to be reflex and just our memories aren't that good.

The other thing that could happen is a board complaint. So a board complaint can sometimes start with one thing and end with something else. So in California we are required to set fees prior to the provision of therapist. So what that means, if I see a client, pretty much the beginning of my first session, I say this is how much therapy costs, this is how much the session is going to be, in fact, even before they come in, I we have that conversation and then we document that we have that conversation. Let's pretend we failed to do that and the client complained to the board and then the board said, gives us your record and so I hand them my record and they find out that I actually didn't even do an assessment which is considered standard of care. Not only could I then have an information against my license because of failure to set fees prior to the commencement of services but I could also have a complaint regarding that law that we were looked at a little bit ago and not completing adequate clinical records. So we can get a board complaint and I want to take a quick moment, keep you guys engaged, answer this question, can behavioral health and addiction providers go to jail relating to clinical documentation oversights? Yes, in some cases, or no, that pretty much can't happen.

>> Thank you, Beth, and yes, everyone, you will see this poll pop up on the screen now. As I said that, 47% of you voted already. I guess you're faster than me. We'll give you about 10 more seconds. Thank you so much for your continued participation in this webinar. As a reminder, any questions you have for our presenter, you can go ahead and send them into the questions box. We've got some really great questions already
for Beth. If for some we don't get to your question, they will get documented in a question document, a Q & A document will be posted on the website with the presenter's answers in about two he can would.

Also as a reminder this webinar is sponsored by ICAN notes, the most clinically robust medically robust software who want to reduce doings time, minimize risk and please stay tuned for a brief demo to connect to this presentation on how to use the EHR ICANnotes. I'm going to go ahead and close the results now. It looks like a little over three quarters of you have responded. I'll share the results and turn that this back over to Beth.

>> Okay. So you said yes, in some cases, 92% of you said that clinician could potentially go to jail relating to clinical documentation oversights. For those of you who said yes, as much as I would love to say, you're not right, in fact, yes, you are right. Though it doesn't happen frequently, it can happen that clinicians could go to jail relating to things relating to their clinical documentation. So I would to spend a minute talking about it and this is one of the scariest things we're going to be talking about today and also one of the saddest, give me just a minute as the slides catch up with us here.

So you have probably seen in the news and you've also probably seen this story of Gabriel Fernandez. Many of us, I'm from the Los Angeles area, so I was actually aware of what was happening with Gabriel as it was happening years and years ago. Now Netflix has made a documentary about what happened. But for those of you that don't know, Gabriel was a little boy that was living outside of Los Angeles and he had within pretty severely abused by his parents and there were tons of complaints and ultimately he died from the injuries because of unbelievable severe at the hands of his parents and there were four social workers that were involved in his care. I know I worked for a county affiliated facility, I am sure many of you worked for county and you know the caseloads are incredibly high and it is a very high stress environment and a number of these social workers that were involved in his care were behind in their documentation. Two of the social workers, after his death, went in to the chart and modified the clinical record to add notes that they hadn't had in there when he passed away. The reason I know about this is because it was all over the news as it was happening. And I should note, I can't bring myself to watch the documentary about Gabriel. It was breaking my heart as it was happening here in Los Angeles.

But the reason I bring this up, there are rare, but there are examples of times when clinicians really can have legal consequences and go to jail relating to clinical documentation choices and oversights and, again, these things are super rare, like I remember doing one of these trainings and it was actually a colleague of mine that I knew from my master's degree and I looked at her and she was like light as a ghost, she had no dollar left in her face and she was terrified and she said oh, my god, I've been doing so much wrong. I said I want to remind you there is not a drone from our board is hovering over your keyboard as you write notes. The provability of these things happening is really quite low however, just like I said, just like car insurance, we have these things in place, we have our notes to protect us in case the bad thing happens.

And like I said, we work with a population that's inherently high risk for self injury, dying by suicide, and for risky behaviors and our notes may be the thing that ultimately keeps us out of jail. An helps prevent negative consequences for us and/or four clients.
So now that I've sufficiently freaked you out. Fear not. Stay with me here. There's a lot that you can do to get your records in tip top shape and now we're going to be transitioning both away from the boring part and the scary part in to what my nerdy self considers the fun part of clinical documentation.

So thank you for hanging with me. I've talked with clinicians, especially private practitioners, that say well, I'm in private practice so I don't need to keep notes and I don't take insurance so it doesn't really matter. So but if we just go back to everything about disability, about reputation, about legal liability, it does not matter what kind of work you do, it does not matter where you work, if you are an addiction counselor, therapist, social worker, clinical worker, you need to have clinical records, it doesn't matter who the pay source is, whether you work for a county, you work for a school. So don't worry. I got you. We're going to be okay. Stay with me and I'm going to help you give you some guidance about how to do this.

So let's talk about the incredibly difficult and hard to understand term of medical necessity. This term was like used against me like a weapon in my first internship and it was like there's no medical necessity and it was like I don't know what that means. So let's talk about it. This is from a wonderful book called treatment planning for person center care by Adams and Greeter. I think it is still available on Amazon. There might be a new edition. It's a wonderful book that I really like. I highly recommend it. But they say, simply stated, the demonstration of medical necessity requires that there is a legitimate clinical need and that service provided are an appropriate response. So basically they're saying medical necessity is twofold that we are establishing that there's a legitimate clinical need and that what we are doing is an appropriate response to whatever that clinical need is.

When we think about medical necessity, imagine a doctor performing a procedure that wasn't medically necessary see and I'm not talking about Lasik or lipo. I'm talking about a major medical procedure. We are considered, in lots of ways, medical practitioners. Our charts are legal documents. They are considered medical charts. So imagine a doctor that did a surgical procedure when they didn't need to.

And this example gives me the chills. There was a example in the news within the last six weeks where a doctor, a surgeon, performed hysterectomies unnecessarily. And most of are you probably going oh, my gosh because it is so awful. It wasn't medically necessary. These women did not need to have their uteruses taken out. And it was a real devastating loss for these families for the doctor to have done this. It is so far outside the standard of care for a doctor to do something that isn't medically necessary.

We, as practitioners, as clinicians, are held to the same standard. We need to establish why we are doing what we are doing, going back to that why that I mentioned earlier. Why are we giving them this diagnosis? What symptoms or functional impairments justify that diagnosis? Are they here for treatment? Why do we think they need to come in twice a week or once a month? We need to keep proving our medical necessity because otherwise it is wasteful and we could get in big trouble for it. Again, if a doctor performed something that wasn't medically necessary, you know that that would be outside of the standard of care. I mean, remember the days of drug reps where you would have them go to a doctor's office and then the doctor would kind of hawk that medication to their patients because they would get a cut of that. The reason
we stopped doing do that is because doctors were delivering services and recommending treatments that weren't actually medically necessary. So keep this in mind through the medical model.

And there's something I call the clinical cycle. Does the assessment lead into diagnose, I does that inform your treatment plan, and do notes reflect that. So notice the puzzle piece from notes feeds back into the assessment. So big money here for us. When we are good at our jobs and our clients are getting better, diagnoses is change, if it changes because they're getting better, the treatment plan changes and then the notes change. What we're doing in session changes. All of these parts need to fit together continually in order for us to establish medical necessity. So it is not just medical necessity is in our notes, it is in assessment, it is in diagnosis, it is in everything we do in the clinical record.

And also pulling from that book again, the Adams and Greeter 2014 guide, most third party pairs will only pay for service ifs they are following, indicated appropriate, efficacious, effective and efficient. So I want to take a moment to brake those down. So indicated means is there an appropriate diagnosis. Many of you have clients that have maybe comorbid mental health or addition -- excuse me, mental health or medical disorders so maybe they also have diabetes or maybe they have a eating disorder. If you are working in an addiction facility but the primary diagnosis is an eating disorder, then it is not indicated for them to be treated with you, and keep this in mind, is it appropriate? So this means the level of care actually matches the client's needs. Efficacious, so this means is there some reason to believe that this service is going to help them? So we no longer uses leeches. We don't believe in bloodletting. We certainly do not believe in lobotomies because they're not efficacious. We only do service when is we believe there is a reason for it to be effective, either some research base or well, really just research base or past experience with that client that this intervention works for them.

And fourth, effective. That means we look back at it and we say it did work or it didn't work. So if we have a client doing EMDR because they have severe flashbacks, let's say, and the flashing backs aren't getting better, we can determine that that treatment isn't effective. What I like to say is if it is not working, change it. If it is still not working, stop it. So if it is not effective we need to stop doing it and if we don't do that, then we're reporting outside of medical necessity. And lastly is it efficient. So unfortunately there are lots of facilities that have committed fraud because they've delivered services that weren't medically necessary or they were billing for clients that didn't exist or using fake Social Security numbers, really gnarly stuff like if you go down this rabbit hole it is kind of horrifying.

And the realize utilization review for insurance companies exists is because some providers were not delivering care in a way that was efficient. So again, most third party pairs will pay for service ifs they are indicated appropriate, efficacious, effective, and lastly, efficient. I really like this definition because I think it starts to break it down. And this one is from the joint commission's 2018 documentation guide, the one I recommended that I really like. If it is done effectively, documentation supports and guides justifies and confirms and communicates. So these are all the words that the Joint Commission is saying they
want to see if they were to describe it. It is complete, high quality, the medical necessity in their laws so in California, a service is medically necessary or for those when it is reasonable and necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain.

So when we think about this one, let's kind of do the smell test here. Are the services that you're providing clinically necessary to protect life to present significant illness or disability or to alleviate pain? All of you should be noting right now. Your charts then need to establish how and why those services are reasonable and necessary. To prevent significant illness and alleviate severe pain. I encourage you, Google your state's name and the words medical necessity or law or code or reach out to your professional association and learn what your particular state's definition is of medical necessity because I think it helps shed some light.

So how many of you work with insurance companies? So you or your company receive insurance like Aetna or Anthem, the tiny ones and not the biggies.

>> Yes. Thank you. So you'll see this we'll give you about ten more seconds to answer that and as you're doing it, just as a reminder, we're going to do our best to end on time and have time for a brief Q & A but if we miss your question, we will answer it on-line on the Q-AA document. Please keep sending your questions into the questions box and we'll pose those questions to Beth during the live Q&A.

All right, everyone. It looks like almost three quarters of you have answered. I'm going to go ahead and close the poll. And share the results and I'll turn this back over to Beth.

>> Good to know. So over half you say that you work with insurance in some way. So more and more people are working with insurance companies and I'm glad you let me know where you're coming at this from. As I've said for those of you that don't accept insurance it is still important for you to establish medical necessity but for those of you who do accept insurance, again, you've probably used this term used, there's no medical necessity for continued care. With insurance companies, they are using their medical necessity guidelines to determine what is medically appropriate and it is really important that you know what those medical necessities guidelines are. So if you accept -- oh, excuse me. The slides caught up with me. If you accept insurance you need to know the medical necessity criteria and the level of care guidelines. This is critical. So this is not your agreement with the insurance company. This is not how much they're going to pay for a service. Every insurance company is required to release their medical necessity criteria and level of care guidelines it. May or may not be widely available on-line. So if you have a client or let's say somebody says Cigna, it is important you reach out to Cigna and get a copy of the medical necessity criteria because it tells you really clearly what's required so, for example, some residential facilities are required by their insurance company by their insurance provider to have 24-hour nursing, for example, whereas other insurance companies don't provide that. But basically in order to get reimbursement from that company, then it requires 24 /7 nursing, you need to have that service in place or else they could recoup the funds because you were not steak -- you were not meeting their basic guideline of what is required. It needs to be everywhere in your notes, so your assessment, treatment plan, progress notes, discharge plan, case notes, any medical or nursing notes. It needs to weave its way through everything.
And in fact it may even be a conversation with a driver as you're on your way to a 12-step meeting with your clients. You never know. But it is important that those things make their way into the chart because jumping back if it is not in the chart, from an auditing perspective, then it didn't happen.

So let's do a quick recap. This is the part I really want you to remember. Medical necessity has two components, not just one. Number one that there's a legit mall clinical need. So, i.e., if there is, we need to establish it in your notes. And number two that the services we're providing are an appropriate response. So basically legitimate clinical need, why did they need it, and services provided, why are we -- why are we doing this to help it, whatever that is, whether it's a depressive disorder or a substance use disorder or whatever.

So now we get to jump to the sparkly part of today, writing progress notes. This is really why you're here. So thank you for sticking with me. I want to introduce you to something that I created really for myself and realized that hey, this might be helpful for other people. So therapists, saving the world one progress note at a time, the safety first mnemonic and this is added as a handout that you can download either during or after today's presentation, so you're welcome to have it and share it. It is something I created.

So let's talk about safety first. The first thing we're going to talk about is safety and then acronym first which is functional impairment, interventions, response, symptoms, and therapeutic interpretation. So for those of you who might have picked up a pencil or pen and trying to frantically write, don't worry about it, the handout has it all broken down for you. But I want to start talking about these and giving you some examples.

So let's start by talking about safety. The reason this comes first is it is the most important thing for us to document. You need to ask yourself I have documented the critical safety and risk factors. If there are any. But when I say safety and risk factors I want to point out so safety factor like here we have this gentleman sitting on this ledge, it is pretty much inarguably a safety factor. A risk factor would be are they at risk of losing their employment because of the substance abuse disorder, are they at risk for depression and poor parenting outcomes as a result of their mental health disorder so it is not just safety but it is also risk. Why do they need to be here? Why do they need this treatment. When you're writing a note, the first thick you should ask yourself, have I documented the critical safety and risk factors? Far and away this is the most important thing you need to get in your note.

Next we're going to move on to functional impairment. How does the individual's condition or situation impact his, her, or their ability to function in important domains like work, school, or home, community, parenting, things like that. So this is one of the things I see missing a lot. We're good at talking about symptoms, like how often something is happening, but we're not as good as talking about how that actually effects that person. So I want to give you an example. For anybody out there named Charles or Chuck, I apologize in chance chuck but I've named this guy. This is my buddy Chuck. Everybody knows a Chuck. So Chuck is when we can go back to work and be an in an office, so asterisk next to that but in a normal day when we're not in a lock down in a pandemic, Chuck walks into the office and he has a bright affect, he's warm, he's funny, he's performing well at work, he and his partner are getting along right, kids are getting to school on time, things for Chuck are g really well. Except for one thing
about Chuck. Chuck regularly drinks one or two bottles of wine per night. And in spite of the substance abusing behavior, Chuck is actually functioning pretty well. He's whether a we would call a quote-unquote functional alcoholic. You know, that colloquial term. And yeah, he probably has some kind of liver issue. But we're not medical professionals. But so when we're looking at his functional impairment, by and large Chuck is pretty much fine.

Here's the thing. So here's me. If I had two bottles of mine in a night. I would have my head in a shrub. I would not have a good time in my marriage, I can assure you that. I would have problems at work. And I would not be able to get my children to school, note, if school were still open and it would be very dangerous for me, not only am a small person but I would have significant functional impairment associated with that.

So I want to go back to this idea and I want you to remember this example. So here we have Chuck who by and large is not that effected by his substance use so if all we wrote in a note is he's drinking two bottles of wine per night, it doesn't tell us if that effects him. But if you wrote the same note about me, she has two bottles of wine per night, you need to say what that looks like for me, what happens because of those two bottles of wine. So as you think about this, please remember Chuck and remember me when you're thinking about functional impairment. That is the other things that needs to be in your notes.

And then interventions, what treatment intervention and what was the clinical reasoning behind it? So this is one of the things that clinicians also struggle with. We're pretty good at saying what a client center did in treatment but we're not so good as saying what we did. We get paid the big bucks because we have clinical reasoning. We are intervening with clients all the time, whether or not we're leading them down a hallway as we're walking them out or if they walk in front of us and we step back to they will let them walk past there was a clinical intervention there, relating possibly to a show of respect. We don't need to document that one, quick note. But we do interventions constantly and that's why we're paid the big approximate bucks so you need to make sure to document it.

Here's an example. Therapists encouraged the client to identify the pros and cons of switching majors in college. Why did you do this? I did it in order to. So my why for this is as a therapist might be different than yours. So let's pretend, I know I work with a lot of young adults, so I do this frequently, let's pretend this client is impulsive and they often switch majors when things maybe get a little bit hard so they've already had three majors in college and they're what we call a super senior and they've had difficulty finishing this education that's really important to them. So I might have encouraged the client to identify the pros and cons in order to reduce impulsive decision making.

So in writing interventions that way with that in order to and the reason, it sells somebody reading it why I did what I did, this part is really important. So let's go back to the power of why, I want to give you an example of this. So we go in to a coffee shop when we can go in to coffee shops again and the person on the other side of the counter says, how you doing, how are you doing? Why are they doing this? So when someone at a coffee shop does this, they are doing this, number one, probably because they've been told to and because it is polite. They're rapidly establishing rapport with us and making us feel comfortable. I'm sure they've there have been studies done about
the effect of comfortable customer spends more money, who knows. So but what we expect that if we go to Trader Joe's or we go to a Starbucks that they're going to say, how are you doing? The reason that they do this, their why is different than why Joey would do this from friends. You remember Joey say, how you doing? Why was Joey doing it. Joey was doing it because he was hitting on someone because that's what Joey did. His why was in order to assess a potential romantic connection, let's say. And then we move in to us. Why would we say how you doing? So yeah, we're doing it because we want to establish rapport but we're actually probably doing it primarily for a more important reason. We are doing an assessment. So in that moment when we say how you doing, we're actually assessing how that client is doing, are they oriented? Are they able to describe for us their current emotional state? Are they really quiet? Do they become tearful? So in order to shows the reader why you did it, so again, why Joey did it, his in order to is different than my in order to would be different than a baristas.

So next moving ton on to response, how did your client respond to you and to your interventions? Do you guys remember when Tom Cruise went on Oprah talking about Katy Holmes and he jumped up and down on the couch? Have you ever had a client do that? So if you had, that's the kind of thing you would need to document. What was your client's response to you, how did they present in the session? Were they really happy and then became very tearful? So make sure that the client is showing up in the net not just by what they did but how they responded and what their.

And last -- not last. Second to last. For symptoms. We want you to document both the symptoms you observe and the report symptoms. Give me just a moment. I need to clear my throat. Excuse me. So symptoms, I have lots of clients who struggle with sleep. So we have this woman here who has insomnia she tells us she hasn't been able to sleep for the last three days and then we clarify what does that mean. I have difficulty following asleep, I can't stay asleep, I ruminate or I wake up a lot. It is important to document both the symptoms that are reported by the client and then what we observe. So did she appear tired? So we would make that observation based on psychomotor retardation, so she might move tired like a sloth. She might have a hunched over way of sitting. She may just have a pretty flat affect. So it is important for us to diagnose the symptoms both that we observe as they're reported to us. And now, finally, last but not least, our therapeutic interpretation. So this might include the compliance or lack of compliance, our clinical impressions, what kind of progress they've made, any relapse potential, their prognosis, the exercise of clinical judgment and our plan. So I want to go back to this concept of clinical judgment. Clinical judgment is what I call your clinical fancy hat. This is a why we get the big bucks because we take all of these symptoms and we go, oh, my goodness, I think you're talking about the associate identity disorder, let's talk about it. Or we say oh, gosh, I know when we've done this assessment about your alcohol use, it turns out that you meet the criteria for alcohol abuse disorder severe, let me tell what you that means. Our use of clinical judgment is really our guide in our we're decision making clinically because what I might do is going to be different than what you might do in a clinical situation and that's okay. Oftentimes there isn't a right way to do something. Most of the time when we're exercising this clinical judgment we have pretty strong clinical reasoning for it and we need to make sure we document that in that therapeutic
interpretation section so we need to say here's why I did it so if I had a client that I referred for higher level of care, if that client has a major risk of overdose because he hasn't used in awhile and that client also has a history of overdose, let's say and has had previous treatment successes at a higher level of care, that's my clinical fancy hat and my clinical reasoning, my therapeutic interpretation that lets me know that it's okay to be referring this client for a higher level of care and then my notes need to reflect that clinical decision making. So, again when, we're talking about safety first, we have savers, the functional impairment, interventions, response, therapeutic interpretation or what I like to call the clinical fancy hat.

So I want to tell you for a minute about the so what challenge. I'm borrowing this from the Joint Commission but I want to give you a quick example here. So here's what I mean when I say so what. Actually let me tell you Joint Commission first. So what says what does this data all mean, doctor? What is my condition? What are my problems? So what should I have to resolve the problems I have, so where do I start. So what can you or others do to help me, what can I do to help myself, what should I look for to watch and see that I'm progressing. These are all of the questions that a client or a patient would ask a doctor. The Joint Commission says these are all the questions that need to be answered in your notes, the so what question, what does it all mean, what is the condition, what are the problems. I have reinterpreted this had in a different way and I want to give you a quick example and I also want to note, the Joint Commission says that it is not that clinicians fail to complete evaluations or identify so what questions, it is just that we don't write them proficiently and sometimes we don't write them at all.

So sometimes it is helpful when you're writing to say to yourself, so what, basically what is the significance. Here is my play on it. Let's pretend I see a note that says client reports that her boss is becoming increasingly more frustrated with her absences, and she was written up yesterday. So me being me, being a little snarky, I might say, so what? So I sit down with the clinician and I say, so what does this mean? And the person tells me, well, she has more stress, which is contributed to her worse insomnia. And I'm look, what does the insomnia mean. The clinician says she's within been using alcohol more. She says so what. She says when she drinks more, she's later for work and then she, she might lose her job. And I say, so what? She says, she's the primary breadwinner and if she loses her job, she's going to lose her housing, more than likely. So do you see how when I asked this imaginary clinician so what, you know, basically what does it mean, why is it relevant, it gets us to document medical necessity so here's what that note should say. Client reports that her boss is becoming increasingly more frustrated with her absences and she was written up yesterday. This stress appears to be to have been contributing to increase in alcohol use in a circular manner. Client's job appears to be at risk, as well as her housing should she lose her job, due to her mental health symptoms and substance abuse.

So in this example we have an extremely clear picture of what medical necessity looks like. So note we have her symptoms, the frequency of those symptoms, and what the risk or safety factors are and how it is effecting her functionally. Yes, not everybody and not commonly do we write this clearly in a progress note, this is best case scenario, but I show you this example because she was illustrating what really needs to be written when we're trying to establish medical necessity. It is not just enough to say she was
written up, it is like what does that mean and to take it the extra step to illustrate how that effects this person's functioning.

So how long do you spend writing an average progress note? Just take a very quick second to please answer this question.

>> Thank you, everyone, you'll see the poll pop up on your screen and yes, we'll give you a few moments to answer that question and Beth, just a heads up, we'll take the next two to three minutes to wrap up.

>> Yes.

>> All right. And we got almost 70%, we're going to go ahead and close the poll with 70% of the answers in. I'll share the results and turn this back over to Beth and please stay, tuned, everyone, in just a moment we will have a brief demo from our webinar sponsor, ICANnotes.

>> Okay. So most of you said that you're spending three to ten minutes, sometimes ten to 20 minutes and some of you longer than 20 minutes. Really a progress note should be taking you less than ten minutes to complete. And with practice, this is going to get easier and it's going to get better four over time but so if you're like me, I used to write novels. It will get better as you practice some of these things. And so if I can get the slides to stay with me here, there we go. As we just said, slides should really take less than ten minutes and if you're taking a really long time it may be that you're writing too much or you're not writing the correct things. So it is normal for there to be a learning curve as you adjust to this. It might actually take you realistically a month or two to adjust to writing the right amount. A good rule of thumb is to write at least one intervention and one response for every 10 or 15 minutes of session. So if you're in a 45 or 50-minute session, it is important then to write at least three interventions and at least three responses for that particular client so that you have enough information in that note to say kind of what happened, and I should note, this doesn't include crisis sessions. For crisis Sessions you're going to write more than that. It's going to take you longer than that. And that's just the deal. So for the average progress note, three interventions and three responses. And like I pointed out earlier that duplicate content in general, don't copy and paste and if you are going to, make sure you only do it carefully only when appropriate and only when it is specifically applicable. It is really important because it is a huge fraud and auditing red flag.

Other quick notes. Make sure to complete a note with each service. Complete all note fields if you're completing an assessment. Make sure to stay within your scope of practice. Many of us like essential oils but we're not qualified to be recommending those kinds of things or supplements, for example, so make sure to stay in your lane, so to speak. And also to make sure you use clinical and neutral language when describing clients and their behaviors. Sometimes we use words like manipulative and I know sometimes our clients say the word manipulative and I see that in a chart but that is counter transference but imagine the client seeing that about themselves. So remember we should write in a clinical and neutral language.

So six quick questions that I want to remind you that you can use to ask yourself as you're completing notes and then we will hand it over to ICAN notes.

So first and foremost is to look familiar. Have I documented a clinical and safety and risk factors if there are any.
Question No. 2, if I had 30 seconds in a case conference to present this session, what would I say? So sometimes we give excessive information notes. For example, we say therapist or counselor worked to establish worth or rapport. But the truth of the matter is we wouldn't say that in a case conference so we don't need to write it in your notes. My goal is to help you write smarter, not harder. So if you wouldn't say it in a case conference as you're presenting the case, it is okay to admit it. Excuse me, omit it.

Question No. 3, why, that big why, why do I think the client needs this treatment? If you keep that in mind, it will help you stay on track to make sure you're documenting medical necessity to remember -- to remind yourself that your notes need to be establishing that consistently not just in the treatment plan, not just in the progress note but always noted.

Question No. 4, is this a summary of the session or is it a play by play? This is what I was super guilty of. Our notes should just be a summary. You don't need to write it like a script. So shouldn't be therapist said, client said, therapist said, client did. It should really just be a summary of what happened and unless it is a crisis session, your notes really shouldn't be that long. So if you notice yourself doing a play by play, cull back.

Question No. 5, is this sentence generally relevant to the gist of the note? So this picture, this woman wearing a green sweater probably not that remarkable, unless, lets pretend she always show up in treatment wearing blah black and in general she had black dark hair and black makeup and clad in black then it would be relevant to her treatment that she suddenly showed up wearing a bright green sweater. Otherwise it's not necessary for you to document that and you can leave it out.

Question No. 6, does the client's actual quote explain this better than my clinical interpretation? I love psycho babble as much as the next person but sometimes we use words like I love the word anedonia but it doesn't really tell us how that effects the person in the real world. So sometimes a client's quote may be more illustrative than just saying the compliant presents with severe depression. If a client says I'm so depressed can't even get dressed every morning and I haven't done laundry in four weeks, that's way more helpful to painting medical necessity than just saying the client is experiencing severe depression.

So --

>> Hey, Beth. We're going to have to go ahead and turn this over to October. I'll just let you have some final words.

>> Thank you. So to wrap up, so we've covered a lot today and as I said, we're going to have those notes handed to you for safety first so you have that mnemonic and today we've talked about everything from medical necessity to some of the consequences of inadequate clinical documentation and also hopefully giving you some guidance. So thank you for joining us today. And I will hand it over to Samson.

>> Thank you so much, Beth. I'm going to hand this over to October Boyles. She's the chief clinical officer for ICAN notes, also registered nurse for over 15 years. ICAN notes, the most clinically robust software who want to reduce their documentation time, minimize their legal risks and is our expert presenter provided us today and code at the maximum level of reimbursement. I'm going to go ahead and hand it over to October. October, you will be the presenter and the floor is yours.

>> Thank you so much. Thank you. I appreciate that. Now, I actually am not able to see my screen so just tell me if there's any delays on the chart face now I'm going to
head in to a therapist note. I know there were some delays with this slide. So when I get on that therapist note if you can, am I there yet?

>> You are there. We see it.

>> All right. Fantastic. All right. Excellent. So thank you so much for attending tonight. I'm the cleave clinical officer for ICAN notes and Beth spoke about the importance of liability. What ICAN notes assisting you with liability issues because we provide you content that you can utilize in your assessment of your clients and one of the great things about the content is it is clear, concise and we have professional statements and you can type whatever you want, verbatim in to ICAN notes. From the -- from the patient statements so but we have assessments that are pertinent to your specialization that includes ASAM and treatment plans that are actually linked to the dimensions, so you have the ability to pull in the treatment plans in each progress note which is really important in your documentation.

I'm going to run through a note and show you hot to produce an excellent note really quickly in less than two minutes so and not only do we have our own content but we have custom content that you can put in like your own statements, your own templates, as you can see, we do a progress note by dimension, I can talk about withdrawal, the patient denies any withdrawal, denies any use and then I can go in to behavior and talk about self care and socialization with others maybe this is maybe it is reduced because of the Coronavirus, right? Functioning at work is maybe marginally because you're doing it at home and sobriety is being maintained and I can talk about anger and impulses, and I can go back into the note and I can talk about verbal content, therapy, substance abuse and this is Piper Chapman from original is the new black, she's having marriage issues and maybe feels a little guilt and loss and then we go in to therapeutic interventions. Are you guys able to see as I'm clicking through? Is it moving?

>> Yes. It is moving perfectly. I see everything. It is great.

>> So I was worried with the delay but I can go in and talk about therapeutic addressing substance abuse, I can talk about maybe utilizing copying skills and improving self compassion and what we did with the client, the support, encourage the client to vet feelings, talk about the importance of abstinence. So and these are the, tease are what is utilized the most about our therapists and counselors, however we have everything from child care to hospice in our pop downs. And so I think so go in and do a MSC, that takes 30 seconds. I can really address with what is going on with a client, insight, judgment, functional levels, if they're distracted, what's going on, withdrawal intoxication for the client is doing great, click normal and move on. So I'm able to produce these great notes. I can justify level of care. I can go in a rating scales. We have a plethora of those. I can link the treatment plan in very easily and I can do a violence risk assessment. It will talk about violent obsessions and it will save it as a progress note and then I get a great note that I only spent a few minutes on but I was able to accurately talk about my client, their symptoms, their behaviors, things like that. And so this the is the note I was able to come up with this in that short period of tame, if you you're using the ASAM dimensions, this note was able to be done in under two minutes as well. So just some things there.

And one thing I want to brought up notes about the practice. ICAN notes are always available to you. I want to tell you what makes ICAN notes so different from other
EMRs because it was created by a psychiatrist and all of the company's leadership team, including myself, is comprised of individuals and we all worked in healthcare, mental healthcare and so we've been in the trenches with you and we have the clinicians' best interests in mind with our AMR. Also training and support is unlimited and free and we have coding specialists and UR professionals that are training and so they help you with your reimbursement and one of the things that I wanted to show you that's really important. Is we are offering a master class. So we want to make sure you that can get the most out of your rates and so we're offering this free master class on maximizing reimbursement rates and what behavioral health services most and frequently get accepted and which ones most and frequently get denied so hopefully this will help you in your reimbursement. This is a special offer. This is for everyone and it doesn't matter if you're an ICAN notes customer or not. You'll be getting that sent out afterwards. And and thank you so much for allowing ICAN notes to participate. I appreciate you.

>> Thank you so much, October. And Beth, thank you for the excellent presentation. I'm going to actually go back to the presentation so you guys can see just hold on one second, so you can see their contact information. October and Beth, we actually had some excellent questions come. In I wish we had time, everyone. We don't. But I wanted to put this on the screen. This is Beth, her contact information. Elizabeth at clearlyclinical.com. You can also visit clearlyclinical.com. Beth may have a promo for you for being connected with NAADAC. She mentioned some opportunities there and Clearly Clinical is a NAADAC continuing education provider. If you have an emergency type of question, one that is impacting your decision right now with progress notes. I would advise you to go ahead and shoot Beth an e-mail. She'll be able to get back to you much quicker than we will. We are going to compile all of the questions sent in and we will send them to both Beth and to October. October, you actually got about four or five questions just now popping up about ICAN notes. We'll send those to you and we will make sure to get those questions answered. And posted on our screen. Bog go ahead and take a look in your chat box, the promo that October mentioned from ICAN notes, our webinar sponsor. There is a hyperlink in your chat box, you can use that hyperlink to go directly to your webpage, you'll also get a thank you letter from GoToWebinar that will direct you to ICAN notes. If you're wondering about your CE quiz and how to access the recording after the live event, every NAADAC webinar has its own webpage that houses everything you need to know about that particular webinar. Immediately following the live event you will find the on-line CE quiz link on the exact same website you used to register for this webinar. So everything you need to know about this webinar will be permanently hosted at www.NAADAC.org slash progress slash notes dash efficiency dash webinar. Very quickly here is the schedule for our upcoming webinars, please tune in if I can, there's interesting topics with great presenters just like today and also in collaboration with the great lakes ATTC we've had a really outstanding response to this free webinar series for professionals.

With this our first one is actually coming up this Friday, March 27th, 2020, at 12 noon eastern time. We have well over 1,200 already registered. Please make sure to save your space in this free webinar series as you see some excellent presenters like Dr. Carlo, Phil Valentine, John, Chris, many, many, many more. You can learn more at www.dot NAADAC.org slash progress slash notes dash efficiency dash webinar.
And as many of you are turning to telehealth at this time, we are pleased to offer a free webinar on Tuesday, March 31st, 2020, 2 to 4:00 p.m. eastern right around the corner to provide you the practitioners and program directors with the information you need to use telehealth during COVID-19 pandemic. If you haven't done so already, please check out our COVID-19 resources page. You seat website here on my slide and it will also be sent to you in the thank you e-mail. Www dot NAADAC.org slash COVID-19-opioid-telehealth-webinar. That’s for the webinar next Tuesday, you can go to our website, you'll also see it in your E blast.

Lastly, as a NAADAC member, you may know but all of your CEs are free. These free educational webinars, that, is the biweekly webinars. You also have free access to the addiction recovery and many, many more. Please note that a short survey will pop up at the end. Please take time to give us feedback, share any of the notes you have for the presenter, the sponsor, and how we can improve this learning experience.

Your feedback is super important to us. Thank you, again, everyone for participating in this webinar. And Beth, thank you for this tremendous training and your valuable expertise. I encourage you all to take some time to browse our website, learn how NAADAC helps others.

You can stay connected with us on LinkedIn, Facebook, and Twitter, and thank you, ICAN notes, for your webinar sponsorship. Have a great day, everyone.