Certification which you guys are working on.

Now, hopefully there will be an advanced

certification coming your way soon, too.

But you guys have been through hours

and hours and hours of this training.

I'm sure you're so ready to wrap up.

So let's get into it.

All right.

So as far as our content in this training,

we are going to review just some basic telemetry

health documentation considerations from our Telemental Health Training Institute

and from the American Board of Telehealth.

Then we're going to talk about Navigating

Kippoo and where everything is there.

Next, we're going to jump into

documenting for each telehealth role.

Now, that would be a ten

hour training in and of itself.

So it will be an overview, and I will

show you where to find these resources for yourself.

And we'll go over some of the basics, but just

know that is by no means a comprehensive look at

everything to do with documentation for your role.

And then we're going to talk about how

to minimize documentation using a presentation from Josh.

And I want to say, Diane, we'll take a look at that.

And lastly, we're going to finish up with

where to locate documentation guidelines and information.

We honestly might do that a

little bit sooner in the training.

Again, welcome to Discovery behavioral

Health training and clinical Documentation.

In the virtual setting, we will review the general

documentation guidelines and where you can locate them.

We will focus on the information pertinent to

virtual programming documentation, and then we will then

review some of the strategies for minimizing documentation.

We will also review how and where

to document within the Ki Poo system.

Our learning objectives are going to be

general documentation considerations for telehealth Navigating.

Keepu effective documentation for virtual at DBH, tips for

minimizing documentation and where to go for further documentation

support, here are five questions that you will definitely

be able to answer by the end of this

training, and hopefully much more.

What is important to know about

documenting for telehealth in general?

How do I navigate the Discovery Behavioral

Health EMR or electronic medical records?

How do I document for virtual programming?

How can I document strategically or make a documentary?

Goodness gracious, where can I find

additional resources on virtual documentation?

So for our general overview, a patient's record

is the way to communicate a patient's care

with various stakeholders involved in a stakeholder.

I think often times we think of

financially, but that's not what we mean.

A stakeholder could be various people

on that person's care team.

So their PCP, their primary care physician

and their therapist and their psychiatrist.

It could also be the insurance company

that is paying for that person's care.

And sometimes we'll call them the payers.

Other stakeholders could be

the family members themselves.

So there's lots of key players here.

And the only way for us to

communicate is via that clinical documentation.

Record retention policies protect patient records.

So these are the rules around how long we

need to keep documents, where to store documents so

we can access them, at which point we do

destroy documents and everything that goes into that, and

then telehealth reimbursement guidelines vary greatly depending on practice,

state service payers, et cetera, and impact documentation.

So oftentimes we do document for that specific payer

because that payer has guidelines for what substantiates medical

necessity for somebody in a specific program.

So in a partial hospitalization program

or in an intensive outpatient program.

And we need to follow those guidelines so that

the insurance will continue to support that patient's care,

they can continue to get care at an affordable

rate, and everything that goes along with that.

All of these policies, again, they all differ by state.

They can differ sometimes by region.

Within a state, they differ by the payer themselves.

So the best thing to do is to know your

ethical guidelines and requirements per documentation, what is required per

year licensure if you are a licensed clinician, what is

required by the insurance company, and what is required by

the state and potentially federal laws.

Now, we set the expectation that we document at

the highest standard, so we document for the most

stringent insurance companies or the most stringent federal or

state laws to make sure that our patients files

don't have any gaps in them, and they could

really be utilized in an appropriate way by anybody

that needed that information.

And that is why documentation

sometimes can feel so heavy.

So to do our documentation, mostly we use KEEPUP help.

Now, there are areas of Discovery Behavioral

Health that do not use Ki Poo.

Those tend to be our substance use

disorder brands that were acquired by Discovery

Behavioral Health in recent years.

But even with some of those,

we've worked on transitioning to Kibu.

But it is our primary electronic medical record.

It's the primary place that clients

and patients notes and documents lives.

So we're going to walk through how to use it

from a technology standpoint here, it's a different project.

Just ignore that.

So you're going to go to that's

not quite what I want here.

It's not opening my saved page for whatever reason.

So I'm going to show you an alternative way to

get there, which honestly might be the best thing anyway.

So if we go to our internet and

let's just demonstrate how to get there again.

So this is how I typically get there.

I usually open up my email and

then I immediately click Discovery Behavioral Health,

and it's going to take me here.

This is our intranet page, and we've

looked at this several times before.

You can see everything that's here.

And then I'm actually going to go to center

for Discovery, and I'm going to go to EMR.

This is just the easiest way for me

to do it, primarily because I started as

a therapist with center for Discovery.

So I'm logged into keeping EMR, and I'm in our sandbox.

So this is so you're not going

to see any patient information, obviously.

And this is my fake patient, Albert Einstein.

So typically you'll see all of the patients listed here

that are currently a part of that specific program.

So you log in using the login information

provided to you, and then everything lives here.

So you can go to the dashboard and this

can show you sometimes everything you need to see.

You can also see your messages there.

I'm not going to click there

because you would see patient information.

This needs to be updated and not an

intern anymore, you know what I mean?

So I would see my current caseload here.

I can see everybody who's in the census.

This is also showing you all of the

documents that this person would need to sign.

And this person would not have every single

document as it does right now, would have

the documents specific to that program.

So, for example, not every program is

going to have a swimming pool.

So many of us wouldn't need that.

You can see here who is assigned as the

therapist and who is assigned as the dietitian.

So, for example, if you're working in center for Discovery

and you're not sure who the other person on the

client's treatment team is, you can check that here.

This is taking us back to our aware

where you can see all of our patients.

That's not what I would use as often.

So here you would see all of

the scheduled groups for that day.

And this is where you're going to find the

group notes that you can update and fill out.

And we'll go over how to do that.

Rounds isn't something you would

likely be using very much.

You can go to their past group sessions.

Rounds is something you're only going

to use in very specific positions.

And we'll touch on some of the ones

that might the context for that specific person.

But typically, I would live my life in Dashboard and this

is how I would get access to everything I need.

This is just a demo account, so

it does not have full capabilities.

So that's how you log in.

That's the general kind of movement about it.

And then let's go ahead and jump straight

over to how do we document Ki Poo?

So we are going to use this packet that

I put together from all of the Ki.

Poo resources that you have

from Discovery Behavioral Health.

So actually, before we jump into the packet, let's look

at how you can access these resources for yourself.

So you're going to go back

here, we're in center for Discovery.

You're going to go to documents, keepu resources.

And I believe that discovery mood and

anxiety has it organized very similarly.

And you can access their resources here as well.

This is the most UpToDate.

So this is where I pulled all of these documents from.

And I just combined them into one giant PDF for you.

However, you can, of course, go

through them one by one.

I will also attach this PDF to the training

so you do have it available for yourself there.

Okay, buckle in.

This is where we're going to get into.

So the Attendance tracker in Ki Poo is used

to indicate whether patients were present or absent for

treatment with their electronic chart on a daily basis.

So we really need to have good ideas of attendance

for insurance, because with insurance, they'll be provided with X

amount of days that they can attend treatment and have

it paid for by the insurance company.

And if you go over that, you may

be inadvertently forcing that patient to pay out

of pocket or something like that.

So it's something we need to stay very on

top of the way that we would complete attendance.

You can either complete it for the entire

facility or you can complete it one patient

at a time through their individual chart.

But regardless, you navigate to Schedules

and then you go to Attendance.

Let's see if that is in my demo account.

I'm not sure if it will be or not.

It sure is.

So we're going to go to Schedules,

we're going to go to Attendance, and

you'll see here what their attendance was.

So here you can see the

date for which you're taking Attendance.

You can navigate to the past dates using

the calendar and you can view how many

current patients have been accounted for.

And this is something we want to be keeping up with.

When you scroll down in the Attendance tab,

you'll see all active patients in your facility.

Here, you can record attendance through

using Actions button for each patient.

So over here, they were here or they were not.

Typically, the mailing manager would do this,

but you also might find yourself doing

it individually for your patients, depending on

what the requirement at your site is.

If you are not sure, please check

with your executive director or your director.

And if they are absent, we

want to say why they're absent.

And that has to do with tracking all sorts of things.

But mostly it's a safety thing.

If they're absent, we need to document why,

because we want to make sure that they're

safe and they are accounted for.

This also will tell insurance why they did

not use that day and why they need

an additional day to come to program.

So to do that, you're going to

click these three little dots here.

You can indicate why they were absent.

This, I think, is the best way to keep track of this.

You can also put it in a note

in the dashboard if for whatever reason, you're

just trying to leave a note for yourself.

But I would put it

in the Attendance tracker, obviously.

All right.

And then to complete or review Attendance, one patient

at a time, you're going to navigate to that

specific patient's chart, click the attendance tab, and then

click the three dots on the right.

So we're going to go here, we're going to

go to patients so we can see which patient.

Let's click on Albert Einstein.

So we're going to open up Albert Einstein's chart here.

Now, one thing you're going to see

is there's a flag for this client.

This client has a shellfish allergy.

Now, I've never said that I've acknowledged this.

I'm going to go ahead and do that.

When I click Resolve.

This message should not pop up for me every time.

You will also see things like this.

If somebody is very high suicide risk,

actually, that would be to say that

they didn't have that issue anymore.

So we're not going to resolve that.

They're not going to resolve an allergy.

I am going to acknowledge it by clicking that.

I and then it will not pop up for me anymore.

Okay, so we're going here.

Now you can see everything that

we would have for this patient.

This is what their face sheet looks like.

Everything, all their basic information.

Now we're going to go to attendance for them over here.

And very similarly, we have everything here.

We can record their attendance there.

Keep it moving.

From this menu, you can also view

how many days have been accounted for.

So you would see their absence reason, so approved

absence or unapproved absence, whatever that might be.

Common errors that we see in the patient chart that

create attendance errors and reporting is there will be missing

information in the start date or end date or something

about the level of care is not indicated.

So to correct that, you want to add that

information and you can hit add, review or edit.

And typically, as a therapist or a group facilitator, you're

not the one making any changes to these charts.

So communicate with your mailing manager,

potentially your clinical director, and they

can go ahead and fix that.

And this is how they would do that.

Okay.

Next, we're going to talk

through group and shift notes.

So to access a group or shiftnote

locate schedule at the very top.

And it's going to take us here and

under scheduled group sessions, we'll click it, hit

start, and we're able to complete that now. Okay.

Now, this is something I think, just so that everybody

on your team is going to find themselves doing, this

is where we're going to document which groups they were

in, what they did in group, all of that jazz.

So we've clicked the schedule, we've clicked the tab

that we needed to click, and then we're going

to find the list of the various groups.

So we're only seeing one.

Again, this is a demo account, but normally you're going

to see all of the groups listed for the day

and you're going to click the correct one.

Then once selected, you're going to be prompted

to set up the notes so start time

or end time should be preset.

However, you can adjust the time.

So if you did something a little different that

day or you were short staffed and you needed

to extend one group, whatever, you can adjust that

time just so everything is accounted for.

Then from the topic, you're going to

select which group you're documenting for.

Let's see if this one does have the so

here you can choose from all of these groups.

So these are the groups that would be

at this particular facility and then it will

populate that group description for you.

Once the topic of the note is selected and

the group description is filled out, you will need

to select patients, select only appropriate age patients.

So if you're running an adult group, you're only going

to be selecting the adults that were in that group

or the adolescents that were in that group.

So this is what it might look like.

We only have our one patient so we'll go ahead

and add Alberta and we'll hit Add selected and now

they're in the group and we can add their notes.

We are not currently using Golden Thread

for this function, although I believe there

are updates coming to that.

So please be sure to attend

any documentation, trainings from Csqm or

Clinical Services and Quality Management.

I'm going to show you their webpage on

the internet and the SharePoint again, just so

you know how to access all those resources

and just keep an eye out for webinars.

So saving and signing a completed note.

So we would go here.

If you have more than one person helping out

with that group, you could add group signer.

But if it's just you, you're going to click

group leader, sign off and submit and complete that.

And then once the group is all

done, we'd be good to go.

So what you're going to put in notes

is going to include group topic, how the

patient is presented in the group.

Did they present as focused attentive? Were they sleepy?

Were they not focused?

Were they resistant to the topic?

A direct quote from that patient.

So patient reported the group was very

helpful because it made them realize they

could use this tool in our life.

Patient reported the group was not very helpful because

they were unsure if it was something they see

themselves using on a regular basis, whatever that is.

Sometimes the groups will have check ins and check out.

So patient checked in by

saying, I'm feeling good today.

Patient checked in by saying I'm having a

really challenging day and in the checkout patient

reported the group was very helpful and added

high points of their day or did not.

Just so we have a full picture of

what they went through in that group.

Do not document excessively.

There is no need to be writing

one page paper on every single patient.

We just need the snapshot of what they did in that

group, what they would have learned, what they got out of

the group, and how they participated in that group.

There's more specific information on documenting in your

onboarding training, and there's more trainings that come

out all the time, and I'll show you

how to access some of those previous trainings.

It's a little bit beyond the scope of

what we're doing to change the group leader.

You'll do that here, so sometimes you might start a group

note and somebody else needs to finish it just for time

reasons, and that's where you're able to do that.

And then to access past uncompleted groups, you're

going to go to change date here.

Locate the group that was not completed

and go ahead and complete that group.

Should all group notes should be completed

by the end of the day.

I'll talk through some of my tips and tricks to

make sure that happens every once in a while.

It will not happen and you want to

get that group note completed as soon as

possible, and that is an insurance requirement.

The completion process of miss notes is the same

as all other notes, so view completed notes.

You can go to pass groups and

see all the notes that were completed.

All right, so let's talk through rounds now.

Again, not everybody is going to be using rounds.

Not all levels of care use rounds, so I'm

not going to go through this one as stringently

as maybe some of the other ones.

To begin documenting observation logs for

rounds, you need to assign the

round to the selected patient's charts. First.

Open the patient's chart.

Navigate to the Rounds tab.

Click on Assign Rounds.

Select a round you need to assign to this patient depending

on what round the patient is on, 15 or 30 minutes.

Select that session.

You may select multiple rounds.

All selected rounds will be highlighted in green, so

we have options here for RTC self harm, 15

minutes a day to RTC day rounds and you're

going to collect the appropriate one.

I did not use rounds at any point in working

in outpatient, so I do not believe they will be

a requirement for you if you're somebody working in residential

or helping residential, this is more pertinent to what you

will need to know as far as documenting around.

Once selected rounds will begin, a timer will begin

to count down until the next round is complete.

During the round, staff will document

the status of the patient.

Select activity and location of the patient.

Click Observe.

If needed, you may log additional

details such as the vitals notes.

Click on List.

Vitals are documented upon the doctor's request.

If no vitals are taken, click no Entry

button, click no Entry, then click Observe.

Once your round has been started or is in

progress, the round can be edited even when missed.

To assign the round, open the patient's

chart and navigate to the Rounds tab.

Click on the drop button next to the round.

You will need to unassign confirm the action

when prompted to add a round leader.

Hit add round leader and then select

that staff member and keep it.

And then here's our rounds and

interval statuses with explanations for each.

Okay, now let's talk about another topic,

which is going to be transferring the

outpatient level of care reference guide.

So either they're stepping down from partial hospitalization from

6 hours of treatment to 3 hours of treatment,

or they're stepping up from 3 hours of treatment

at IOP to 6 hours of treatment at PHP.

And this did recently change you staff to fully

admit and discharge between each level of care.

And it was very tedious.

Sorry.

I'm going to go ahead and plug my computer in now.

The charts are combined, and that

is a much more efficient process. So big.

Thank you to Operations for making that happen.

So, again, this is not something

everybody is going to be doing.

This is something primarily the Milieu manager will do.

So you're going to go to the patient's face sheet.

We'll go ahead and look at it.

Back to our patient, back to Albert Eisen.

So we're on our information page.

So we have our start date and our end date.

So here's our start date and our end date.

We have our Allstate Scroll down a little bit. Actually.

Here we go.

Here's our concurrent reviews.

Here's our start date and date and our authorization

date so we can see their status, their level

of care, their frequency, status, level of care frequency.

So either say IOP or PHP or RTC in

this case, but we're really working with PHP or

IOP patients for the majority of the virtual programming.

I'm not sure I'm going to have permission to do this.

So that's where you could change their number of days

and you can change their level of care there.

Just make sure that you're following these protocols

and then progress note clinical in the first

session with the patient upon transitioning to the

new level of care, reassess for patient needs

and document with clinical progress notes.

So if the patient reports new needs, goals,

problems, or exhibits new symptoms, this needs to

be reflected in the treatment plan and diagnoses.

Let's take a quick peek at where those live.

I don't want to mess anything up,

so we're going to close that.

All right, so this is

where clinical progress notes live.

So for our therapist, this is

where you're doing your documentation.

So you'll be adding your note, clinical progress note,

or if you're adding an absence note, which is

a little bit more of an explanation of why,

if they're transitioning to or from a hospital.

I don't think you guys are going to see

this in there if you're not at RTC.

We do have some specialized clinical notes as well,

which may or may not be available to you.

And this is where you would complete that note.

We'll get it into a little bit more of

what that looks like here in a second.

And then treatment plans live here.

So just making sure that

they're being updated regularly.

You're never going to see any I really

hope you never, ever see anybody with that

many trees plans, but you never know. All right.

And then just indicating if there's

been changes in those notes.

And then same thing with our dietary progress notes.

Let's take a peek there.

So this is where our dietary progress notes live.

And again, you're going to add form.

Choose the correct form that

you're doing the documentation for.

Complete that form.

And if we're updating any statuses as far as

levels of care or just changes in treatment plan,

make sure they're indicated in your clinical notes.

Discharge planning also has its

own tab that lives here.

And then just make sure you're up

to date with what is required.

As far as discharge planning, we will go

through a checklist of which documentation is needed.

So for whatever reason, they

left against medical advice.

You're going to be completing that and then potentially

the clinical discharge summary and the discharge plan.

But again, things we are working to

help optimize a lot of the documentation.

So just make sure you're up to

date as far as what is required.

And then let's take a peek at the Census Tracker.

The Census Tracker has moved, so

that'll be depending on your program.

So it used to be in Google.

We don't use the Google Census Trackers

anymore because now we have Microsoft accounts.

So make sure that your director has

shared the Census Tracker with you.

Okay, let's talk about auditing.

This is primarily for our

million managers or Millieu coordinators.

You guys are going to be the ones doing the auditing.

So to do that, you're going to go to Charge Summary.

So there's our tab right here.

And you can see everything that populates.

Then each item in the summary is an active

link, so clicking on it will open the corresponding

document and will contain all of the information here.

Any form that is an open status

will not appear in the Chart summary.

Open forms appear on the

dashboard within their designated tab.

So an open form is going to

be something that is not completed.

To see things that are open, you're able to check here.

I just wanted to get the senses. Sorry.

Back to our patient.

Here we are.

So you need all of the documents to be signed to

really be able to look at them in the chart summary.

So we're going to audit after admission.

So we want to audit 72 hours after admission.

Please ensure that the following items have been

completed and are present in the patient's chart.

They need an uploaded picture, so you can see

Albert Einstein has his gorgeous headshot that says picture.

And then to add that picture,

you go to Information tab.

On the chart, click on Edit

Patient which is right here.

Choose File for their photo.

They have a photo, but if you wanted

to update it, you click right there.

You also want to make sure that they have all

of their admission consents saved and signed and locked.

So required consent indicates consent for adolescence only

is something you'll see with the little red

star and then it indicates consents that need

to be created and resigned when transitioning between

levels of care will be the blue star.

Let's take a look at these consents.

We are all done editing this and I don't want to

make any changes and mess up poor Albert's file here.

So we're going to go back to the face sheet.

These are all of the consent that they need and

it will tell you what is the level of care.

So some of them they need residential

and outpatient, some of them they only

need outpatient and they only needed residential.

We just want to make sure

that everything involving that is done.

We have some preadmint stuff here and then we'll

either have our adult consents or adolescent consent and

Albert Einstein or Albert Einstein in here is an

adult, so they only have the adult consents.

And to add a consent, you'll go here.

We want to make sure those

have all been added appropriately.

They have all been signed and completed.

All assessments have been completed.

Search for the assessment using Chart Summary

tab and this will show you everything

that's been done for this client.

The required assessments and notes can be

searched in Kiku under the following titles.

So to do that we're going to go to their

Chart Summary and we can search for what's been done

or not been done and you can search right here.

Your main manager is doing the audit.

They're making sure that all of that is

done in time, but you also need to

make sure that those consents are completed.

That is a part of your due diligence as well.

So don't leave that all on your Mm or MC.

Make sure you're supporting them and getting

everything done to audits are done weekly.

So this is when the Mm is going to go in

and make a list of everything that was done or needs

to be done or was not done on time and send

it to the therapist so that the therapists and dietitians and

other members of the treatment team know what needs to happen.

And this is different between RTC and PHP and IOP.

To make sure you're referencing this list as far

as auditing group notes, you're going to go to

Schedules tab and then pass group sessions.

Ensure that your facility does not have

any in progress notes because that would

mean that they are not completed.

If they are not completed, make sure you include them in

the audit so that the clinicians and just members of that

team know that that note needs to be done.

Ideally, that note was assigned to somebody and you

know exactly who needs to complete that note.

If it's a group note that nobody has

started but you know Susie Q, the group

facilitator is assigned to that group every week.

You can assign them that note and then they will

get a notification to go in and complete it.

All right.

Uploading and Auditing Attachments So when uploading an

attachment into any tab, follow these steps below.

You hit Add Form Attachment and

then you can attach it there.

So let's do that in where

is straight up notes these days?

And here you can attach a face sheet.

You can attach step down,

packet, lapse, EKG, MSE, everything.

Once you click that, it'll populate just like

this and you complete all of that and

this walks you through everything else as well.

Audit after Discharge So same thing after discharge,

everything needs to be completed within 72 hours.

Using the Chart Summary tab, you're going

to sort through the following notes and

ensure that they've been completed.

Deficiency Tab Report So for any staff

member who are missing or needing to

complete notes, complete the Deficiency Report tab

located in the weekly Chart Audit Sheet.

And again, this is for mail

you managers and mail you coordinators.

And then they're going to email out these

chart audits at least once a week to

the program director, to the regional director of

that facility viatraining@discoverybh.com if staff members do not

correct their documentation as prompted in the time

allotted, corrective action will be taken.

And then if you ever, ever have any issues with Ki

Poo, maybe you forgot to add someone to a group note

or you need to add them after the fact or you

realize you made some sort of mistake in a document.

Email Ed QPU at Center Forddiscovery.com.

They are very honored.

They will get back to you in 30 seconds, so

please don't hesitate to reach out to them for support.

And every division, I believe has

their own keep in support team.

So just make sure if you are not a

part of center for Discovery, but maybe discovery, mood,

anxiety, you know who you're reaching out to.

And all these team members are awesome.

They will help you.

All right, we're a little over halfway through here, so

keep a consent and how to populate for All Levels

of Care So as far as creating consents, again, William

Manager, Clinical Director this is for you.

This is not for my therapist.

This is not for my dieticians.

Typically in Kibo, you have two options

for creating consent and patient charts.

One option is to auto populate forms in Patients

Charts, select the tab consents, Select Populate with Forms.

Let's see if it's set up that way here.

So Alberta does not have that option,

at least not that I see.

But you may for your specific key

posts, just make sure that you're familiar

with that Select Populate with forms.

This will automatically populate all consents that

live in this tab specific to the

level of care for the patient.

It will not populate if other templates are present.

So remove any consents that do not apply for that

patient by selecting the red X and that's easy peasy.

It looks like that option to add forms individually.

So if a patient or inpatient chart select

the tab consent again, our consents live here

and that's where you're able to add them.

Remove any consents that do not

apply by clicking the red X.

I got a little confused, I guess.

Select Add Form and select each individual consent

applicable for that patient and then for sending

consents to patients and or Guarantors via Keeping

Messenger, you have the options to send patients

or Guarantor's consent to sign prior to admission,

assuming the patient or Guarantor is set up.

In Keeping Messenger navigate to

the Keeping Messenger tab. Please.

Please make sure your patients are set up and

keep the messenger when they admit for virtual and

if this is something they need help with getting

set up, make sure you are on that.

The Clinical Director and the manager coordinator are probably

going to be your Keepu Messenger rock stars.

And sometimes patients just really struggle to get the Keepo

Messenger accounts set up and that's where they're going to

be able to find all of their documentation.

So make sure they have it set up.

They know how to use it.

They're good to go because otherwise you are going to

have a payday, not a good hay day tracking down

and getting them to fill stuff out eventually.

Keeping Messenger I hope I'm not mistaken on this, but

it's going to become a client portal or a patient

portal and it will be even easier for them to

log into their portal and to complete all their documentation.

And to my knowledge, that rollout is coming in April.

Right now they're still using Keeping Messenger.

So for Keeping Messenger, you're usually going to

need to select that keep a messenger form.

I don't see an example here.

I just want to show you guys

the difference between the Keeping Messenger one.

So here you can see this.

One says Keeping Messenger.

So sometimes you'll have two forms, but one says

Keeping Messenger and one doesn't say Keeping Messenger.

If this is something that needs to get to them.

Keeping messenger, which usually means they have no ability

to sign in person, it needs to be emailed

them to them in a HIPAA compliant way.

You need to make sure you're sending the Keeping Messenger

one and then the ones that are non Keeping Messenger,

most often they need to sign in program.

All right, so we started going over this, assuming

the patient or Guarantor is set up and keep

the messenger navigate to keep the messenger tab.

But anyway, you can see the specific Keeping Messenger

forms and then once added to the chart, click

the drop down and select the guarantor.

So after you add that Keeping Messenger form,

sometimes you might need to select which parent

it's going to or just the parent period.

Typically you're sending these to parents, but you

can also be sending them to client.

So select that specific form it's going to go

to, hit send, and then it's off to them.

You just got to make sure that they complete it.

If Keeping Messenger templates have not been

populated in Keeping Messenger tab, the Guarantor

has not activated their account.

So if the Guarantor or Guardian is not activated

and it's on site, they can still sign in

to keep a messenger, for they can still sign

the Keeping Messenger forms in person.

However, virtually if they need to have that Keeping

Messenger account set up live and ready to go.

Similar as before, the red star indicates consent

for adolescents, and then the blue star indicates

consent that needs to be created and resigned

when transitioning between levels of care.

So just be mindful of those.

And as you guys can see, this is all very

well organized and accessible information for you and once you

have mastered it, you're going to be good to go.

It seems like a lot at first, but as soon as you

get a handle on it, it's not going to be a problem.

You guys are going to be pros.

I think this is actually what we just

went through, so we're going to keep going.

All right, keep intake and information fishy

Guide So, clinical Director, listen up.

No, this isn't good information for our

clinicians, for our dietitians and for our

group facilitators, because it is.

But you're not going to be the one

doing the face sheet most of the time.

So click this symbol which

indicates all pending patients.

A list of all pending patients

being pushed through will display.

Click the preview for the patient who

is admitting, which is right here.

A face sheet preview will pop up.

At this point, you will be

presented with two options to proceed.

Either readmit or accept.

Pick the correct option.

You can read a little bit more

about that there and see it here.

Once accepted or readmitted, the patient

will be displayed as accepted.

The patient's case file will then be found in pre

admission on the census page specific to your location.

Click on the patient case file and

in the Information tab, click Edit Patient.

Select the program and verify that the location and

admission date, which has been auto populated is correct.

If not there, you will

need to add appropriate information.

For RTC only, you're going to select

the two sets of Q 30 rounds.

Unless the patient is on self harm.

Verify enter in auto all correct demographic information,

including the patient's name, birth, sex, date of

birth, address, city state and Zip.

When the patient arrives, you will then

create the medical record number or Mr.

By selecting this, the patient's chart ID will

be provided and the patient will be considered

admitted and part of the current census.

How to create new patients in keeping who

have not been pushed through via Salesforce.

So if it does not auto populate, if they're not

there for you, you're going to be adding them.

So on the Census page, the

main page will have patient tiles.

Click New.

I want to show you that it's not showing up for me.

So that's okay, here we go.

I'm just not doing it right.

So you're going to go to Census page New.

Again, this is a demo account, so I'm not entirely

sure what we have and what we don't have available

to show you, but we'll just keep going with this

because I want to be efficient with time.

So you'll hit New, you're going to input

all basic demographic information, including their name, admission

date, location, and then add the patient.

After clicking Add Patient, you're going to be brought

to the Patient's Information tab or Face sheet.

At this point, you're going to follow all

the steps from above for an accepted patient

and then complete the Insurance section.

If not pushed through via Salesforce and Salesforce

is the program that our admissions team uses

to intake patients, but for whatever reason, they

might be direct admitting without having gone through

the typical admissions process, it happens.

So this is when you're going to

put this in for your program.

So you're going to select a payment method.

Which payment method that patient is using.

Typically it's insurance, putting in all of

their insurance information, usually from their cards,

and then entering insurance information.

Please make sure all necessary information is included.

We need to have a policy number,

a group number, a relationship between whoever

has that insurance policy and the patient.

The subscriber name, subscriber address, City, State, Zip

and then if you do not know the

address, then please just use the patient's address.

Subscriber date of Birth If the patient is a

private pay or scholarship, please Select Add Form.

Under the Insurance Information section,

Select Cash Pay Client.

As you can see here, scroll back down to

the Insurance section and Select Complete the form with

the information regarding payment terms, payment terms, ie.

Start date, date of change, all of Care under

Comments enter details for how many days they are

privately paying and the rate and how many days

are scholarships and who was approved by.

Again, if you have questions on any of this, reach

out to Ed Koopoo or whoever your Kiboo managers are.

They're the most helpful, important items

to remember for insurance entries.

If the patient is a private pay

or scholarship, you can skip this section.

When entering insurance, though, you will see the

insurance name and following number is the number

for the address, so the PO box or

street numbers or street address numbers, please enter

the insurance according to the insurance listed under

the Claims address from the Verification of benefits.

Bob means Verification of benefits.

Some plans will be carved out so the main insurance

is not who the claims will be sent to.

Kibu needs to reflect the claims insurance to

accurately push the charges to the billing program.

So for example, if you're entering Cigna insurance, type

Cigna into the search bar and you will see

a few choices of Cigna with the numbers.

Please choose one of the plans in red.

These plans are automatically set up to

work directly with the billing program.

Choose the insurance which matches

the claims mailing address.

This may vary from Insurance who will be

authorizing treatment and then Insurance naming exception.

Due to the length of name, some of the Blue

Cross plans are listed as BCBS, so Blue Shield Blue

Cross or Blue Cross Blue Shield of XXX.

If you do not see your plan under Blue Cross, please type

in BC to see if it comes up for authorization info.

If the company providing the authorization is

different from the Billing insurance, please enter

the Authorization Insurance name and contact information

in the Notes section under Insurance.

Let's talk about the Keeping Flags feature and

this is an enhanced Urgent Issues feature.

So what is a flags feature?

The Keepue Urgent Issue functionality has

been enhanced and expanded to include

predefined categorical flags in several levels.

Red means critical, yellow means

warning and blue means informational.

All flags will be displayed in the upper right corner

of the patient chart with a number inside indicating the

number of flags for that severity in category.

Flags can be assigned to begin or end on a

particular date or remain open until resolved or dismissed.

Click on any one of the flags will

reveal the details of that specific flag.

So let's go ahead and go see Mr.

Alberta here.

Let's look at our warnings.

So we have a gender identity disclosure.

We have a revocation of the release and then

that they are an Ata against therapist advice, ACA

against clinical advice, or just AWOL risk.

You can also see AMA or against

medical advice or against treatment advice.

Clicking on one flag will reveal

the details of that specific flag.

Clicking on the Gray flag icon will reveal all

the active flags on the patient and provide the

ability to add a new flag in the moment.

Patient Flags red flags being critical and these are

going to blink and they're going to pop up

automatically when the chart is accessed until resolved.

And I did show you how to click that.

You have seen that you just click that little I

function and then it won't pop up every time.

And sometimes issues can be

resolved and sometimes they can't.

So with high suicide risk, ideally, as

soon as they get to moderate or

low suicide risk, that issue is resolved.

You don't need to have it on there anymore.

But something like a shellfish allergy is always

going to be an active critical risk.

And you need to just say that you've seen

that you know that is happening and then it

won't pop up for you every time.

High suicide risk, alarming medical concerns

and allergies would all be critical.

Red flags, yellow flags or warnings.

That would be our Ata risk, ACA

risk, AWOL risk, revocation, a release of

information so decided that somebody should not

have access to their health information anymore.

The fact that they're on bed rest or they

disclose a diverse gender identity or gender identity different

from their own blue flags, medical related is necessary.

Approved dietary modifications, maybe they're gluten free

or lactose free, whatever that might be.

And you will also see their pronouns listed there.

Creating, acknowledging, resolving, and canceling patient Flags

You're going to go to flags.

You'll be able to select the type of flag

based on the predetermined categories, the start date and

date, if applicable, applicable, and any necessary comments that

would be beneficial for staff to be aware of.

And then that check Mark is how you would resolve it.

If you are not that person's therapist,

you're probably not resolving that issue.

If you are that person's therapist and things change

appropriately, you can go ahead and resolve it.

And then if you have seen the issue, if you click

that little eye, it won't come up for you every time.

And you can also cancel a patient's flag if

it was something that didn't need to be there.

And this is what the flag details

look like in the patient's chart.

So you can sign notes from the dashboard.

So clinical documentation requiring a supervisor review signature

within 24 hours of that have been created.

So if you are a registered intern or

an associate counselor, you're not fully licensed.

You need signatures.

This is where they will be able to do that.

They're going to go to Dashboard current

census and they'll be able to see

everything they need to sign for you.

That's typically our executive program directors.

Program directors keep your chart, audit reports.

For this, you're going to go to reports,

and then you can pull the reports for

the group sessions, shift notes, or for the

patient evaluation, audit, whatever you need to pull.

And this explains how to do that.

This is for internal transfers.

So if somebody is transferring from one of

our residential programs to one of our PHP

or Outpatient programs, we have that here.

Again, this is typically one of

our program directors doing this.

So there's three types of internal transfers.

There's transferring to a new level of

care between different center for Discovery facilities,

transferring between different center for Discovery facilities

within the same level of care.

So perhaps to a virtual program from an in

person program and transferring to a new level of

care within the same facility or patient discharges.

So it's going to be like our step ups or step downs.

And here's the steps you need to take.

I'm going to breeze through this just a little bit

quicker because I don't think it's as universally helpful.

But if that is something pertinent to you have there.

All right, let's talk about our outcome measures.

So in every area of discovery, behavioral

health, we have some sort of outcome

measures that we are collecting information on.

The Ras, which is the Recovery

Assessment Scale and the PHQ nine.

Patient health Questionnaire are two

of the most common.

And these are things we're going to administer throughout

treatment to see if they are getting better.

So you can see here when these need to be completed.

And then as far as setting up measures for all

patients, complete the steps one to seven below upon admission

and then complete steps two to seven below every week.

Mm or MC.

This is typically you as well

complete steps two to seven.

And here's your steps.

So you're going to go to outcome measures,

you're going to click enroll, you're going to

enroll them in the appropriate assessments.

Click Prepare, select the boxes again, prepare, and

then you can see that they're ready.

And then the therapist is going

to complete those with the patient.

Sometimes the Mm does need them to be

completed or has the bandwidth and they will

go ask the patients to complete them.

But more often than not, the therapist

is asking the patient to complete them.

In an ideal scenario, they are sent via keeping

messenger to the patient and the patient does them.

But sometimes patients don't know they're there,

just don't complete them despite being prompted.

So you may find yourself doing these in session,

and then you can view the results for these

and see how these change over time.

Okay, so that is our Kiwi presentation.

And then just one more time to show

you where to document, to document notes.

They live here for clinicians.

You're going to go here, you're going

to add a clinical progress note.

You're going to complete that note.

There are more specific trainings on that.

Same thing with treatment plans, your treatment plan.

You do need to do a problem list as well.

Dietitians here.

Again, there's more specific trainings and all this stuff, so

I don't want to hash it out too repetitively.

Okay, then we're going to take a little break and

then we'll finish up almost there and we're back.

So we went over how to document in keeping

again, pay attention to the specific clinical documentation, clinical

treatment planning, all of that jazz from I just

cannot keep messages from popping up here from your

other divisional training for your position.

If you have any additional questions, don't hesitate to reach

out to me, your program director, or anybody else from

your operations team that can support you here.

And as always, do not forget to reach out

to Edkeu or your specific keeping support team.

And they can really help with a lot of this.

All right.

Let's talk through some lessons from Csqm.

So the big thing here the thing I always

want you to remember about documenting for telehealth is

you have to document locations and you have to

document that the service is being provided via telehealth.

So this is something I pulled

from their master documentation PowerPoint.

I'm going to show you where these PowerPoints live, and I

am going to attach all of them to this training.

They have so many resources for you guys in terms

of documentation, which is why I'm not going over it.

They're the experts for a lot

of this more in depth stuff.

So let's talk through this slide, and then

I'll show you where to find these resources.

So how to document Ki Poo effective documentation.

Master presentation is where I pulled this from.

And these are our tips for telehealth.

So make sure to identify telehealth sessions appropriately

by saying this is a telehealth section.

Patient met with clinician via telehealth.

Patient participated in telehealth

session from their home.

Patient participated in telehealth session from

their school or wherever they are.

We need to have that physical location of where

they are participating in these services from documented.

We have gone over from an emergency management

perspective, from a security and Privacy perspective, from

a licensing perspective, why that's so important.

But it has to be in the note.

And if it's not in the note, it didn't happen.

If it didn't happen, it's unaccounted for.

That's a problem we can't build for it.

It's a breakdown in the client's quality of care.

We need to make sure it's documented.

So here's a few scenarios.

So therapist and patient are physically present in

the therapist behavioral health company office, and the

patient's family is zooming in for a session.

So maybe they're not coming in because

we don't want to increase exposure.

They just can't come in because

they're at work, whatever it is.

So you need to document that.

That's a telehealth session.

So even though the patient is in

session with you there in your office,

their parents are participating via telehealth.

Document that appropriately.

Another scenario might be the therapist is in

discovery behavioral health company office and receives a

call that their patient is feeling symptomatic, is

unable to make it to session, but it's

requesting a virtual session.

So this isn't something we always allow.

But in some instances, if a patient cannot come

into physical program and they're participating in a virtual

session when they wouldn't normally make sure you document

it or you're on a remote team and you're

working from home and the patient is at their

home, make sure you document it.

And again, you're going to document that.

But putting it in the group note as well.

Patient participated in session via telehealth via

telemental help via Zoom from location.

All right.

And then let's make sure there's nothing

on this next slide we need.

So this is what we're going to go ahead and look at.

So we're going to go to the Csqm

resources and then I'm going to show you

where to find these presentations for yourself again.

I will link them or attach them to the end of this.

Thank you.

The end of this presentation as

well, just so we can start.

So we're going to go here.

We're going to go to the intranet, as we always do.

We're almost there.

Look, it's me.

Goodness gracious.

I didn't know that was there. All right.

And then we are going to go to Csqms page.

Actually, we're going to go to departments.

So here's our Department.

We want to go to

clinical Services and Quality Management.

Our CSQ and people are incredible,

just like everybody else is incredible.

I am so thankful to be able to work

with everybody that I get to cross paths with.

And I think that this resource is just fabulous.

All right, so we're scrolling.

We're scrolling.

We're scrolling.

Here we go.

So we're on our Csqm page.

We've scrolled and we scrolled and we're going

to go to our clinical quality resource room.

And this is all of the stuff you

guys need to document efficiently and effectively.

There's a ton of stuff here.

But what I want you guys to focus

on is this effective documentation training from 2001.

And you're going to find your particular division.

So if you work in Discovery, Moon,

Anxiety, MH is what you're looking for.

If you work for a substance use Brand,

Cliffside, Casa, Palmera, Prosperity Park, all of you

guys, Sud is what you're looking for.

If you work for center for Discovery,

you're looking for the Ed PowerPoint.

We're going to take a peek at the Master.

But before we go there, we have our Ed clinical.

So if you're a therapist within the eating disorder

division, if you're a dietitian within the eating disorder

division, if you're a nurse within the eating disorder

division, if you're a therapist within the DMA division,

if you're a mental health tech, this is going

to be in the DMA division as well.

Substance use therapist, substance use nurse.

This is a safety attestation training.

This is RTC documentation for nurses.

So your resources are here.

They have done the work.

We're going to take a peek at

their Master where everything is put together.

But for you guys, I would definitely

recommend just pulling the one you need.

And that's because this is 98 slides, but

they did set it up really fantastically to

where I think you can click here.

If you wanted to go just to the

Master, we're going to test it out.

And these, I believe, are all links. Perfect.

And it takes you right where you need to go. Okay.

So let's look through what you might see here.

I guess we will start with

let's go to the clinical one.

Thank you.

So for clinical, we're going to be doing

group notes, and this is how you're going

to fill out your group note.

And again, this is in here for

Ed therapists and substance use therapist, and

everybody's got their information here.

So when you're not sure how to document,

this is where you're going to come.

You're going to come to this folder, you're going

to pull up your specific presentation, and you're going

to go through how you need to specifically document.

Once you get in the habit of doing

this correctly, you're going to be fine.

It's just learning it at the get go.

That can be a little tricky,

but it's pretty easy peasy.

We do have our tips for telehealth in here,

and that's what we went ahead and reviewed.

So for telehealth, this specific thing you need

to know about telehealth documentation is you have

to indicate that it's a telehealth session and

you have to indicate their location.

Okay, so that's it.

That all lives here for you.

And we're going back.

Our subtitles are not working today, so

for our documentation checklist, this is something

else I wanted to run you through.

So for center for Discovery, this is

in the Clinical Resources folder in SharePoint.

I showed you guys how to get to

SharePoint, how to locate stuff several different times.

There's definitely examples of it prior previously done

in the training that you can reference, but

this is a really great tool.

I'm sure Discovery Mood and Anxiety has the same thing.

Your facility also probably has this, and if it

doesn't, go ahead and make one for yourself.

So what is the documentation checklist?

What do you need to make sure you

have at your specific level of care?

This one is outpatient for center for Discovery, so

I would legitimately have one of these for every

single one of my clients, and I would take

notes on it as I was providing them care.

And I would set reminders for myself using

my task list in Microsoft to do their

treatment plan updates to do their Ur forms.

And I always said it like two or three days

early knowing that I'm going to get super busy.

But that way it just took the stress away from

me of always feeling like I had something to do

or always being worried that I was forgetting something because

I really had my tasks very, very planned out.

And that might not be how you work, and that's okay.

But figure out what the workflow that is helpful for

you that's going to reduce your stress, and that's going

to allow you to feel competent and on top of

things and just stick to your checklist.

I think the most difficult thing for me was

the Ur forms and the care of coordination notes.

So careful coordination notes are

when you're writing down.

I spoke to this patient's doctor.

I had to make a call to

this patient's parents, whatever it is.

And care coordination could take a

long time to document that stuff.

Some care of coordination is required like, you are

required at certain checkpoints in treatment, like at admission,

discharge and midpoints, and treatment to check in with

collateral sources, figure out how to do that in

a way that works for you.

Are you somebody that prefers phone calls?

Are you somebody that prefers email?

Do you find it easier to document email

versus a phone call, whatever that is?

And sometimes you're at the mercy of whoever

you're working with as that collateral provider.

But you can also set that standard for yourself of

like, I will communicate with you via email, period.

That's what I found.

That works for me.

That's what I found is easiest to document for me.

And also, when you're making these

calls, set limits on them.

So don't call and just say like, oh, yeah, I got an

hour call and say, I have 15 minutes if it's appropriate.

Sometimes it's not.

Same thing with parents.

Hi, I'm calling.

I have 20 minutes to talk and set a timer on them so

they know when you guys need to wrap up so you're not on

that phone with that parent for an hour and a half.

We need to set boundaries with parents and then

collateral support members of the team like the PCP,

just like we would our patients to keep ourselves

safe, to keep ourselves moving throughout our day. Okay.

Went off on a little bit of a tangent there.

Let's go ahead and peek at this.

So minimizing documentation and

documenting for Medical necessity.

So this was put together by Diane and Josh.

All right, so the items that we're going to

cover in this training, we're going to speak to

medical necessity with creating substantial documentation in less time.

So let's learn the why.

So why is it important?

It's important to document medical necessity because that is

what the insurance is going to look at, and

that's what's going to allow them to decide what

they're providing as far as treatment days for this

patient or providing as far as just reimbursement.

And if an insurance company decides that medical necessity

is not there so the patient does not medically

require this treatment, they can stop paying.

And that can cause an intense amount of

stress and financial burden for the patient.

So make sure you are documenting medical necessity.

Make sure you are making it very clear why

this patient needs treatment and how they're benefiting from

treatment on an ongoing basis and how being in

treatment keeps them safer than if they were out

of treatment for whatever specific issue you're working with.

We also need to be justifying level of care.

We don't want a patient to be forced to

step down to IOP when they really need PHP.

And we need to be explaining why PHP is the appropriate

level of care for that patient and why they need to

stay there until the point that they need to step down.

So looking at our audience, we want to make sure

that insurance patient has a rep and that they talk

to their rep about average length of stay.

So we want to make sure that we typically

have centralized Ur, but we don't always have you

are and you are means utilization review.

So this is like how much of what the

patient is being allotted from their insurance company.

It's like coming down the pipeline.

I'm not explaining this as well as I could.

So with CFD, we oftentimes have centralized Ur, so

we have a dedicated person for utilization review that

you fill out the urban check in forms for.

So the utilization weekly check in form and you say

everything that's going on with that patient so that representative

on the Ur site can contact the insurance company and

ensure that we are still getting days or that we

need approval for like five more days of treatments, like

another week of IOP or PHP, whatever it is.

If that communication does not happen effectively again,

that patient could be not kicked out of

treatment be discharged from treatment before they're ready.

We want to make sure that we're planning patient

treatment based on the length of day of insurance.

So if we know that it's an insurance company that

really only gives a limited amount of days for that

patient, the treatment plan needs to accommodate that.

We know we're only going to have

them for X amount of time.

So we know that there's issues that they're not going to

be able to work on with us, and there's ones that

they are, and we need to have that roughly planned out

so that the patient is getting everything they can from treatment

while we have them and has a plan to get those

other needs met once they discharge.

We want to make sure that we're talking to

the family about length of stay as well so

that they don't feel caught off guard, like the

rugs pulled out from under them when they're told

that their kiddo is discharging before they're ready.

So these conversations need to be ongoing.

We also want to be able to look at the

Insurance's medical necessity and you can either look on this

online or you can ask your Ur rep.

And sometimes the program directors just know

this because they're rock stars, right?

And they can give it to you too.

Every insurance company has different medical

necessity criteria, and some of them

are more generous than others.

So if you're ever not sure and you

know that you're getting a lot of pushback

from a particular insurance company, go read their

medical necessity criteria and document specific to it.

Focus on Medical Necessity criteria.

So using the most stringent payer guidelines

to justify to make sure that they

are getting authorization from their insurance company.

So the insurance company is authorizing

that they will pay for services.

So we want to on an ongoing

basis, we want to justify the diagnosis.

So why do they still meet

criteria for substance use disorder?

Why do they still meet

criteria for obsessive compulsive disorder?

Are there safety concerns?

What are the maladaptive behaviors?

What are the functional impairments?

What medications are they on?

What are their treatment goals?

And a lot of this comes

naturally through our documentation process, regardless.

But just keeping all of this in mind

and we want to keep it simple.

You should not be writing two page long

clinical notes unless it is absolutely necessary.

The insurance company wants to know

if they medically need treatment.

So that's the question you're answering.

You don't need to document every single

word that they said in session.

I have seen some really long clinical notes.

Do not do that to yourself.

You need to document in a way

that correctly includes the information accurately answers.

Does this person meet medical necessity

for this level of care?

That is your job.

You are not telling the story of that session.

It does not need to be an erratic use.

Direct quotes.

You can use rating scales from one to ten.

Always identify safety concerns.

For example, suicidality, self harm,

hunger strike, substance use.

All of that jazz needs to be indicated.

You want to explicitly describe their MSE.

So what is their mental state? So where they focus?

Where they alert?

They engage in treatment.

The ADLs is their activities of daily living.

Are they able to take care of themselves?

Have they been taking showers?

Are they able to get up and go to work in the morning?

If they're going to work, are

they able to complete school work?

And if not, write that down?

I'm not sure what W andl means, so I'm going

to leave it ensuring that clients diagnoses correspond with the

treatment goals and clinical language used in the truck.

So if you have not included what you're

talking about in the treatment plan, you need

to amend that treatment plan, especially if it's

become a major treatment focus.

So if you are working on body dysmorphia and you're

trying to reduce the distress that they experience in their

body, body dysphoria needs to be a diagnosis included in

their chart, or it needs to at least be represented

as a problem in the problem list.

Otherwise, you should not be spending your

session time working on it because it's

not been an identified issue.

I'm just going to say this while I'm thinking about

it, because it was not in our earlier presentation.

I know that this is definitely in

Csqm's presentations, but it's just that important.

Make sure that whatever division you are in, you

have the appropriate diagnosis as the first diagnosis listed.

So, for example, in the eating disorder division, even

though they might have very severe depression, if the

depression is more severe than the eating disorder, then

they might not be in the right place.

The eating disorder always needs to

be the first diagnosis listed because

they're an eating disorder treatment program.

Same thing with mental health.

If they have an eating disorder listed, then they

need to be in the eating disorder division.

But if the depression is worse and

they struggled with some sort of eating,

but that can be treated appropriately.

In the Discovery Mood and Anxiety program, make

sure a mental health diagnosis is listed first.

Same thing with substance use.

So at admission, we want to be documenting why now?

Why treatment, why now?

That should be in every intake

or biopsychosocial or clinical admission notes.

Whichever one you're done, what are the impairments?

What can't they do that we're hoping by

the end of treatment they'll be able to

do what necessitates this level of care?

Were they unsuccessful at a lower level of care?

Were they unsuccessful in outpatient treatment where they

were only seeing a therapist once a week?

That's what the insurance needs to know.

How are we going to help them with this issue?

What specific evidence based interventions

are we going to use?

Yes, we are going to use talk

therapy, but are we also going to

have them in dialectical behavioral therapy groups?

Almost certainly because that's something we do pretty

much throughout Discovery Behavioral Health, our cognitive behavioral

therapy groups, what symptoms cannot be managed at

a lower level of care?

Because if it could be, why are

they at this higher level of care?

You need to specify that document acuity,

severity and frequency of current mental health,

eating disorder or substance use symptoms and

behaviors, activities of daily living, impairments, risk

factors, safety concerns, meds.

And each of these can be one

to two sentences if done correctly.

And succinctly.

Again, you're not writing a novel.

Smart Goals be specific.

Make sure that the goal is measurable that

you can quantify with some sort of numbers,

whether that's your outcome measures like your Recovery

Assessment Scale, what have you.

Make sure it's attainable.

So if they don't have their AA yet, it

might not be attainable for them to be getting

into law school by the end of program.

But maybe they have started to reach out to

AA programs and then let's look up our Smart

Goals grid and just look at it that way.

That might be a little easier to digest.

In case you're not familiar with Smart Goals.

Come on, we can do it.

Come on, we can do it.

We know that we can do it.

The only thing with Smart Goals is

everybody does a little differently relevant.

So we want to make sure that what

they're working on is relevant to them, and

it's actually going to be helpful.

We want to be able to document that sometimes.

I see R is reasonable and that's meeting

what attainable means in this specific graphics.

So just making sure that whichever one you're

using, you're hitting all of these points.

I also see ours realistic, so it just depends.

But it's relevant to them.

It's realistic for their life.

It's something they're actually going to be able

to do and actually going to be benefiting

from and then time bound or time based.

So there's an end date.

We know when they're going to be able

to accomplish this specific thing and that's definitely

something you want to be considering in your

treatment plan goals as well.

Moving right along maybe easier way to

go through this guy treatment plan.

We want to make sure that we include

all barriers and diagnoses in the treatment plan.

Each diagnoses requires a treatment goal.

So if you have six diagnoses and you have

one treatment plan, you need to go take a

look at it because you have to redo that.

Please include same goals and interventions we are

providing to insurance in the treatment plan.

So if we're telling the insurance company in

the URLs and in the clinical progress, note

that the patient is working to reduce their

anxiety symptoms, make sure that shows up in

the treatment plan and that's being accounted for.

And then if we update the intervention

and goals, please also make sure this

is reflected in the treatment plan.

We do have smart goals laid out.

I apologize.

So here we do have realistic so speed specific.

Make sure what you're setting up as far as

goals are measurable attainable, realistic and time based.

And we just talked about what all that meant

and they have an example here for you.

I'm also including this PowerPoint as

a resource for this training.

Examples of measurable goals and measurable interventions and

then specify barriers to level of care.

Lc means level of care.

Why do patients need a requested level of care for RTC?

Do they need 24 hours monitoring?

They should if they're RTC at PHP?

What necessitates 6 hours of treatment or what

necessitates 3 hours of treatment for IOP?

Or why will this patient be unsuccessful

at a lower level of care?

Ll O-O-C lower level of care, for example?

Is there a lack of support?

Is there a lack of support?

Are they medically unstable?

Are they at risk of harming themselves?

Is there an underlying barrier needing to be addressed?

We're almost there.

She can handle this gap.

And are we documenting safety concerns?

If there is a safety concern for this client and

it's not in the chart, it never happened and that

it's not appropriate, it needs to be in the chart.

Reassessment and then treatment team of progress Notes So for

all of these notes, have the interventions help the patient

meet their short term or long term goals?

Is the patients for responding to these interventions?

If they're not responding, what's our plan?

What's the contingency plan?

Why do we feel that the interventions are

not helping the patient meet their goal?

So we've done everything we can to hold the

patient accountable and then assessment and reassessment needs to

be done verbally and in the treatment.

Note a minimum of every two weeks, but we

recommend weekly when to step up or step down.

So have they used all of their authorized days?

If not by singing and program, are they

going to benefit from using those authorized days?

More than likely, the answer is yes,

especially with telemedical health or virtual treatment.

The deciding factor of whether telehealth or virtual

treatment is effective in almost every single study

done on it is length of stay.

So how long that they're in treatment.

So if they have authorized days, try and use them.

Is there anything more that we can

do at the current level of care?

Have we done every single thing possible?

Have we titrated the patient properly and made

sure to integrate what we needed as far

as their skills into that level of care,

into their functioning at that level of care?

And then as the patient met their realistic

goals with given interventions based on the baseline

tips and tricks for lower acuity, we want

to make sure to focus on functional impairments.

So this is when a patient is presenting

as needing less care, but we know that

they need some care, and we're worried otherwise

if we don't document effectively that they will

be discharged for the insurance not authorizing days.

So we want to make sure to

focus on functional impairments for these patients.

What are they not able to do in their lives that

by being in treatment, we will help them to do better?

We want to look at the patient's

baseline versus their current function and behavior.

So where were they?

Where are they now?

What is their baseline? Are they at baseline?

Can we get them above baseline?

We want to look at the patient's treatment and

relapse history and how we address potential barriers.

Have they relapsed five times before?

Why is it incredibly important in this moment of time?

We are working on relapse prevention skills, and even

though they're lower Acuity at this point in time,

why is it beneficial to still be in treatment?

We want to look at the patient support and

accountability, making sure that their support team is doing

what they need to for that patient, making sure

we're holding the support team and the patient accountable.

And then we want to look for barriers to

make sure that we have specific goals and interventions,

making sure that there are no barriers to reaching

their goals or to applying these interventions.

And if so, are there things we can

be helping them move or work through?

And if not, documenting why?

If a patient is very high acuity

so they need more intense help.

We want to look at the patient safety risk, make

sure that all safety risks are documented in the chart.

We want to look at the patient

historical decompensation and why they're decompensating currently

and why they're getting worse.

We have tried everything to stabilize the patient.

So, for example, we've tried outside interventions.

We've tried referring them to medical

providers that they needed, working with

their supports for accountability.

Making sure all of this is documented.

What is the patient's motivation and why will a

higher level of care assist with motivational barriers?

So how will this continue to help them

get to where they need to go?

How will this reduce harm for all barriers to

make sure we have specific goals and interventions.

So if there's a barrier, what are we doing about it?

If we can't do anything about it?

Documenting that this is a really great presentation.

And if you ever have questions, you can

reach out to Joshua Lucker or Diane.

I always say Diane's last name wrong, but Diane s I

think it's Sage, but just hopefully I'm not butchering it.

And they can be amazing supports here.

Okay, guys, we're almost there.

All right.

Tips for concurrent documentation.

Excuse me.

I think especially as a virtual provider,

you should always be concurrently documenting.

Meaning you should always be documenting while you're

in that session, while you're in that group.

Again, you should not be writing a novel.

You should be writing a succinct, clearly laid out

note documenting medical necessity, what the patient was getting

out of that group or that individual session, and

what they will need to work on to continue

to get closer to their treatment plan goals.

You are not writing a memoir.

I've seen so many long notes, and I just

feel so bad for everybody that's stressing over those.

So when you're screen sharing, make sure that you are

not sharing your entire desktop as I've been doing now.

And you've seen, like, my team's messages pop up.

Don't do that.

Make sure you're sharing the specific window

that they're meant to be viewing.

So if you're sharing a video, if you're

sharing one of the Sway presentations, you're only

sharing that window on your computer.

And then in the other window that you're not

sharing, you can open up, keepu, and be documenting.

I recommend creating for yourself

a template for every note.

So my template looked like topic of group

was blank, group discussed, participate in activity, whatever

it was blank, blank, and blank.

So if it was an expressive arts activity and we're

working on shame and guilt, group worked to process shame

and guilt via an expressive arts activity, using the medium

of their choice or using markers and paper. Whatever.

I incorporated check ins and check out for all

of our virtual curriculum, and I encourage you to

do the same, even if you're not using that.

So at the beginning of the group, the patient reported

they were in a good mood or a bad mood,

or the patient reportedly excited for expressive arts.

Or they weren't.

And I do designate specific check in or check out

questions, and you're obviously welcome to do the same.

That's your chance to grab that patient quote, right

a little bit about what they worked on.

So it was an expressive arts activity.

Patient created an artwork depicting a fight between them

and their mother patient reported the activity was very

helpful and patient checked out by saying, I hope

we do more expressive art groups, whatever it was.

I think if you are not somebody that feels

super comfortable doing concurrent documentation like that in group,

at least put bullet points for each patient so

you can even copy and paste just three blank

bullet points for each person in that group.

And as they're talking right down bullet points.

So you remember, because if you go through the

group through the day and you've led seven groups,

you may not remember, especially if you are not

able to sign that note up.

Always be running on the therapeutic hour.

So that means 50 minutes, not 60 minutes.

And that group at 50 minutes, they can hang

out on the computer, they can take some deep

breaths for themselves, do what they need to do.

And in that ten minute break,

you're going to be documenting.

You will have already laid out the template, you will

have already had your bullet points and now you're just

going to fill everything in and submit that note done

check, because otherwise you're going to end up at the

end of the day with a lot of notes and

it can feel very overwhelming.

So just making sure that you are documenting

as you go and you are virtual so

you are always on your computer anyway, do

your best to work towards concurrent documentation.

I also try and set up my notes during

check in, so whenever I'm checking in with them.

Hi Susie Q.

What's your check in?

And I'm setting up the note.

I'm putting my template in.

If I'm using a template, I'm setting

up the bullet points and I'm putting

at least something for every single patient.

I'm adding them to the group as I

can see that they're in there with me.

If I know so and so is in an

individual session, I'm making sure to add them and

indicate that they're in an individual session.

All of that jazz.

But if you wait to set that note up, you might

forget who's in session and you're going to be sending a

lot more messages to Edie Koopu, whoever your gods of cup,

who are to add people to that session.

My final thoughts are we did it.

You guys completed the basic trading.

It wasn't perfect at all moments, but you've done it.

You've done it.

You've learned so much.

You've heard me talk more than any

human ever should, and I appreciate you.

If you have any additional recommendations for trainings in

the future, please reach out and let me know.

Or let your executive director now

and they can let me know.

I hope that you are very

excited to use these resources.

I hope that you are leaving this

training feeling even more competent and competent

in your role than you already were.

Then you already work because you're all awesome and that's

why we're working with you in the first place.

However, this is the first volume of this training.

It's the first iteration of it and

it will only continue to improve.

So I would love your feedback.

I would love to work with you if I'm not already.

Other than that, I hope that you have a great day.

All right, here's our summary and then we're all done.

Clinical documentation is the backbone of

clinical care that allows various stakeholders

to communicate for the patient's benefit.

There are specific considerations we need to

keep in mind for documentation when virtual.

We reviewed where to find additional information on

appropriate documentation, how to document effectively in the

company wide electronic medical record and what is

required as far as documentation.

We also touched on ways to minimize

documentation and some other tips for documenting

when virtual thank you so, so much.

Here's our dancing Queen.

Here's some more happy people to say you did it.

You completed the whole thing so from here you are

going to receive a certificate and a digital badge.

If you don't receive that within 24 hours it

might mean that the notification slipped past me.

Please send me an email and just let

me know that you completed this training.

My email is on the previous slides.

It's in every single presentation.

That way I can get that over to you and

then you will always be able to look back at

this training, access this information if you need it but

other than that have a great day. Thank you so much.