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MCTAC 3rd Annual Documentation Event

May 13th, 2026

Albany, NY

Funded by NEW YORK STATE | Office of Mental Health

Agenda for the Day

- Welcome and Introductions
- OMH and OASAS Panel Discussion
- Strengthening Compliance and Quality in Behavioral Health
- Effective Documentation for Group Services
- Lunch + Networking with EHR Vendors
- Artificial Intelligence (AI) Innovation in Behavioral Health
- Building a Community of Practice
- Conclusion

Housekeeping

The slides will be available after today's session.

Material contained within this presentation is informational only and is not official guidance. Providers should refer to state guidance documents for official guidance.

EHR Vendors Tabling Throughout the Day:

Cantata Health Solutions
Medi-EHR
PrecisionCare

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Introductions

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Managed Care Technical Assistance Center (MCTAC) Team

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OMH and OASAS Panel Discussion

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Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS)

- **Julie Lloyd,** LCSW-R (she/her/hers), Director of Adult Clinic & Integrated Services, OMH
- **Shannon Fortran,** MA, MHC, IMH-E® (she/her/hers), Director, Youth/Families Clinic, School-Based & Integrated Services Unit, OMH
- **Danielle Olsen,** LMHC, Director, Adult Treatment Services Unit, OASAS

Panel Discussion (Part 1)

Core elements of notes:

- Are start and end times required to be on each progress note?
- How should risk, safety concerns, or crisis-related issues be reflected in routine progress notes?
- What are the rules around the use of minor siblings' names in children's clinical notes? Allowable or not allowable? Is this a HIPAA violation?
- Can you describe the documentation requirements for progress notes and treatment plan updates including required signatures?

Non-Billable Activities

- What are some tips and tricks for documentation of non-billable services?
- How should providers document missed appointments, outreach attempts, and engagement efforts?

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Disclaimer: General recommended practices are likely applicable across programs but please refer to Program-specific guidance and Standards of Care for more information.

Panel Discussion (Part 2)

Engagement and Encouraging Individual Choice

- What should providers document when an individual declines recommendations, interventions, or referrals?
- What if there are multiple areas of concern identified during assessment but the individual or family does not want to address all of these areas. What do we write on the treatment plan?

Practices and Workflows

- What practical documentation tips can help reduce staff burden while maintaining quality?
- How should providers document when multiple staff members are involved in the same service or intervention?
- Can we complete documentation with the family/individual during sessions and count this time as billable time?

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Disclaimer: General recommended practices are likely applicable across programs but please refer to Program-specific guidance and Standards of Care for more information.

Panel Discussion (Part 3)

Assessment and Intake

- We typically don't have enough time to gather or answer all of the questions during the assessment/intake process, or the families/individuals do not want to answer the questions and disengage.
  - If we don't have all of the info, can we still admit the individual?
- Can assessment be done after admission and can we still bill for assessment after admission?
- How often do providers need to review the treatment plan with the individual/family?

Artificial Intelligence (AI) Usage

- Can program staff use AI platforms like ChatGPT or other documentation-assistance platforms, to help summarize progress notes or aid with other clinical documentation?

Disclaimer: General recommended practices are likely applicable across programs but please refer to Program-specific guidance and Standards of Care for more information.

Strengthening Compliance and Quality in Behavioral Health

Tarra Pratico, CIA
External Audit Liaison
Office of Mental Health

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NEW YORK STATE | Office of Mental Health

OMH & OMIG: Working Together to Support Quality and Compliance

MAY 13, 2026

Office of the Medicaid Inspector General (OMIG)

Who is the OMIG and what do they do?

- The New York State Office of the Medicaid Inspector General (OMIG) is charged with coordinating the fight against fraud and abuse in the Medicaid program. This is done by evaluating data, performing audits and reviews of Medicaid services and providers, conducting investigations and working with other federal and state agencies that have regulatory oversight or law enforcement powers.
- OMIG's mission is to "enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds, while promoting high quality patient care."

Audit Overview

OMH Bureau of Audit & Compliance Services Overview

- The OMH Bureau of Audit & Compliance Services (BACS) authority is outlined in 14 NYCRR §552. OMH is accountable to the public for the resources provided to carry out services within State-licensed or operated facilities and program units that fall under its auspice.
- BACS helps maintain and strengthen the fiscal and operational integrity of the mental health service delivery system by ensuring that systems of fiscal checks and balances are in place along with effective management practices.
- Audits are conducted commonly based on risk and may be requested by OMH Central Office and Field Office management.
- Types of Audits:
  - Financial Audits
  - Compliance Audits
  - Performance Audits
  - Investigative Audits
  - Technical Assistance Reviews

OMIG Audit Overview

- OMIG conducts audits of Medicaid expenditures across an extensive range of provider and payer types.
- Audits are conducted by OMIG's Division of Medicaid Audit, Third Party Liability Contractor, Medicaid Recovery Audit Contractor, and the County Demonstration Program.

Additional details surrounding the OMIG audit process.

Planned audit activities for 2026.

OMIG Audit Contact Information

- If you have any general questions related to an audit, please contact the Division of Medicaid Audit at Audit@omig.ny.gov. For questions on specific audits, please contact the audit staff assigned to the review.
- For questions pertaining to a Medicaid Recovery Audit Contractor review: RAC Contact Information.
- For questions pertaining to Third Party Liability reviews: TPL Contact Information.

OMIG Audit Protocols of OMH Programs

What are audit protocols?

- OMIG documents that summarize audit criteria in reference to rules and regulations governing specific program areas for a retrospective period of time.
- They reflect a specified, previous period of time as OMIG audits are conducted retrospectively.
- Protocols are working documents for auditors, used as guidelines in their efforts to identify violations of rules and regulations.
- Audit protocols are intended solely as guidance.
- Audits focus on the criteria listed in the protocols, but additional findings may be uncovered during the audit.
- Protocols are not substitute for a review of the statutory and regulatory law.
- Additional details surrounding OMIG audit protocols can be found in the following Power Point presentations which can be found here:
  - Protecting the Integrity of the New York State Medicaid Program
  - Overview of OMIG's Audit Process

How are audit protocols developed?

- Protocols are developed in consultation with state regulating agencies, including OMH.
- OMIG's review process is outlined below and can be found on their website.

Stages of Protocol Development

Phase 1: OMIG subject matter experts research and review relevant laws, regulations and program agency guidance. Initial set of protocols are drafted.

Phase 2: Draft protocols are sent to program agency for review. OMIG and the program agency collaborate to discuss the program agency's feedback. OMIG then revises the protocols as needed.

Phase 3: OMIG conducts an internal review that encompasses both quality assurance and legal review.

Phase 4: Provider associations are given the opportunity to review the drafted protocols. OMIG reviews all submitted association feedback and revisions are made as necessary. The protocols then go through a final review by OMIG. After the final review, the protocol is published to OMIG's website.

OMIG's website also contains frequently asked questions which can be found HERE.

Current OMIG Audit Protocols for OMH Programs

OMIG currently has active protocols in place for the following OMH programs:

- Community Rehabilitation Services for Adults
- Comprehensive Psychiatric Emergency Programs
- Continuing Day Treatment Services
- Day Treatment Programs Servicing Children
- Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS)
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS)

Each of these active protocols can be found on OMIG's website.

New Protocols in Development

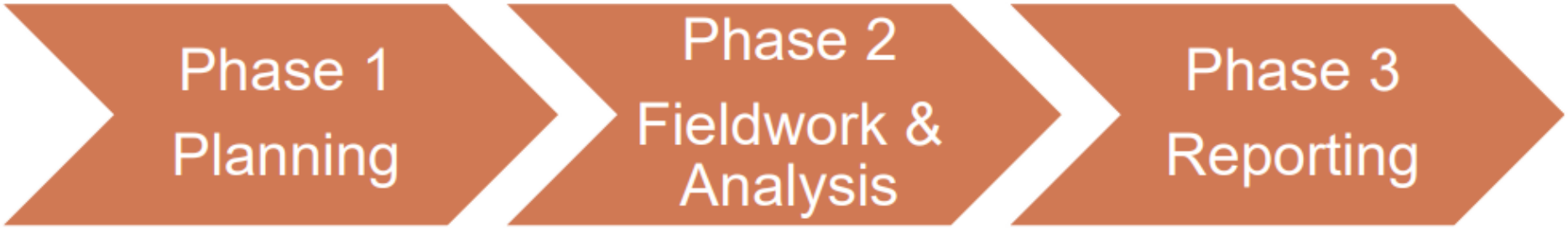
According to the OMIG's website there are several new protocols in development including the following for OMH programs:

- Certified Community Behavioral Health Clinic (CCBHC)
- OMH – Telemental Health
- Children and Family Treatment and Support Services (CFTSS)

OMIG Field Audit Process

Audit Flow

- OMIG held a webinar regarding their audit process which can be found on their website. (See 2025's "Overview of OMIG's Audit Process".



Fieldwork

- During the fieldwork portion of the review, auditors will request original and complete case records.
- To ensure the integrity of the audit, the specific date of service is not shared with the provider until fieldwork is complete.
- Audit staff review the randomly selected sample of claims and supporting documentation.
- As appropriate, any missing documentation or other questions/issues related to what is being reviewed will be communicated to the provider.
- Allowed claims or any with preliminary findings are recorded as the fieldwork progresses.
- The objective is to determine whether the services rendered by the provider were in compliance with Medicaid rules, regulations and policies.

Audit Objective

WERE THE SERVICES RENDERED BY THE PROVIDER IN COMPLIANCE WITH MEDICAID RULES, REGULATIONS AND POLICIES?

Correct Dates Billed

Appropriate Rate or Procedure Codes

Records Contained the Documentation Required

In Accordance with Regulations and Provider Manuals

Claims for Medicaid Reimbursable Services

Reporting Process

- Exit Conference Summary
  - Received prior to exit conference. Opportunity to provide additional documentation/information.
- Draft Audit Report
  - Issued after review and consideration of new documentation/information presented at or after the exit conference.
  - Provider has 30 days to respond
  - Regulations require that issues raised at an administrative hearing are limited to those contained in written objections to the draft report.
- Final Audit Report
  - Contains repayment options and hearing rights
- Summation Letter

Sampling and Extrapolation of Audit Findings

- A random sample of claims is selected from the audit universe.
- Audit staff review the randomly selected sample claims and make findings of disallowed claims (if any).
- The disallowed amounts are then projected over the sampling frame (universe of claims) to arrive at an estimate of the mean dollars in error which is reported in the draft audit report.
- OMIG's auditors may also calculate the lower confidence limit for a given confidence level and report this information in the draft audit report.

Sample Extrapolation

Audit Statistics

Universe Size	2,760
Sample Size	100
Sample Value	$ 227,240.13
Sample Overpayments	$ 19,549.88
Confidence Level	90%

Extrapolation of Sample Findings

Sample Overpayments	$ 19,549.88
Less Overpayments Not Extrapolated*	(4,618.64)
Sample Overpayments for Extrapolation Purposes	$ 14,931.24
Sample Size	100
Mean Dollars in Error for Extrapolation Purposes	$ 149.3124
Universe Size	2,760
Point Estimate of Total Dollars	$ 412,102
Add Overpayments Not Extrapolated*	4,619
Adjusted Point Estimate of Totals Dollars	$ 416,721
Lower Confidence Limit	$ 172,361
Add Overpayments Not Extrapolated*	4,619
Adjusted Lower Confidence Limit	$ 176,980

Best Practices

OMIG outlined several best practices in their training on the audit process, including:

- Understand who needs to be involved in the audit process and ensure that they are available and accessible.
- Understand the process for storage and retrieval of records.
- Advise the audit team of bankruptcy or self-disclosures.
- Communicate with the auditors throughout the process.
- Consider adjustments to the compliance program to address issues identified within an OMIG audit.
- Assess self-disclosure obligations.

Compliance Overview

OMIG's Bureau of Compliance

- The Bureau of Compliance (BOC) works to educate, assist, and assess Medicaid program providers in meeting their obligation to establish and operate effective compliance programs by evaluating whether they are meeting the mandatory compliance program requirements.
- BOC assesses the compliance programs of Medicaid providers to ensure they create a control structure to reduce the potential for fraud, waste, and abuse, and have systems in place to identify and self-correct errors before the Medicaid program is billed.

Additional resources, including the Compliance Program Review Module, can be found here on OMIG's website: OMIG Compliance Library.

Compliance-related questions can be directed to OMIG's Bureau of Compliance at (518) 408-0401 or compliance@omig.ny.gov.

Who Must Have a Medicaid Compliance Program?

NYS Social Services Law Section 363-C and Title 18 of the New York Codes, Rules, and Regulations Sub-Part 521 defines those factors that requires providers to have a Medicaid compliance program.

If you answer "Yes" to any of the following questions, you are required to have a compliance program in NYS.

- Is your organization subject to Article 28 or Article 36 of the NYS Public Health Law (PBH)?
- Is your organization subject to Article 16 or Article 31 of the NYS Mental Hygiene Law?
- Notwithstanding the provisions of § 4414 of the NYS PBH, is your organization a managed care provider, as defined in SOS § 364-j, which includes managed long-term care plans?
- Does your organization claim – and/or can be reasonably expected to claim – Medicaid services or supplies of at least $1,000,000 in any consecutive 12-month period?
- Does your organization receive Medicaid payments – and/or can be reasonably expected to receive payments – either directly or indirectly, of at least $1,000,000 in any consecutive 12-month period? Indirect Medicaid reimbursement is any payment that you receive for the delivery of Medicaid care, services, or supplies that comes from a source other than the State of New York. For example, if you provide covered services to a Medicaid beneficiary who is enrolled in a Medicaid Managed Care Plan, the payment you receive from the Managed Care Organization is considered an indirect payment.

Compliance Program Requirements

Benefits of a Compliance Program

- Serves to mitigate risks associated with unlawful or improper conduct
- Enhances program effectiveness and efficiency
- Allows provider to demonstrate a positive track-record of performance
- Early detection and reporting minimizes loss to the Medicaid program from false claims and may help providers avoid exposure to recoveries, civil damages, and penalties.

Consequences of Not Having an Effective Compliance Program

Potential exposure to increased operational, reputational, service, and audit risks as well as sanctions and repayment of identified Medicaid overpayments.

These consequences may lead to:

- Monetary penalties up to $5,000 for each month that a provider fails to adopt, implement, and maintain an effective compliance program. (This may increase to $10,000 per month for a second violation.)
- Recoupment of monies paid to the provider during the period in which it did not have a compliance program.
- Termination of the provider's enrollment in the Medicaid program.
- Sanctions, up to and including exclusion from participation in the Medicaid program.

Elements of an Effective Compliance Program

There are 7 required elements of an effective compliance program:

1. Written policies, procedures, and standards of conduct
2. Compliance officer and compliance committee
3. Compliance program training and education
4. Lines of communication
5. Disciplinary standards
6. Auditing and monitoring
7. Responding to compliance issues

Please review the Compliance Program Guidance for additional details.

Reporting Fraud and Abuse

In addition to reporting fraud and abuse to the provider's compliance officer, Medicaid misconduct may also be reported:

- Directly to the OMIG by phone at 1-877-87-FRAUD (1-877-873-7283) or via their website.
- To the NYS Office of the Inspector General by phone at 1-800-DO-RIGHT (1-800-367-4448) or by email to inspector.general@ig.ny.gov.
- To the NYS Attorney General's Medicaid Fraud Control Unit at 212-417-5397 or via their Medicaid fraud compliant form.

OMIG Compliance Program Review Process

Compliance Program Review Process

- OMIG conducts ongoing compliance program reviews to determine if providers are meeting their compliance program obligations.
- The focus of the review is to determine if the provider adopted, implemented, and maintained an effective compliance program during the review period that satisfied the Medicaid program requirements.
- OMIG notifies the provider about the compliance program review and associated time period.
- Upon notification, the provider will download the review module, which can be found in the OMIG Compliance Library. The completed module must be submitted (along with applicable supporting documentation) within 30 days.
- OMIG reviews the completed module and documents and may reach out with questions or to request additional documents.
- The provider is notified of the results.
- The provider should identify and implement corrective actions in all areas identified by OMIG as needing improvement.

Compliance Insights and Best Practices

In 2024, OMIG issued 72 compliance program assessments and 11 discontinuance letters according to their 2024 Annual Report. They identified the following areas where providers performed well in these reviews:

- Designating a compliance officer who is responsible for the day-to-day operation of the compliance program.
- Ensuring the compliance officer (and appropriate compliance personnel) have access to all records and documents, information, facilities, and affected individuals.
- Implementing a designated compliance committee comprised of senior managers that meets at least quarterly.
- Maintaining lines of communication that allowed for questions regarding compliance issues to be asked and compliance issues to be reported.
- Maintaining a method for anonymous reporting of potential fraud, waste, abuse, and compliance issues.
- Enforcing disciplinary standards fairly and consistently.
- Reporting, returning, and explaining Medicaid program overpayments.
- Taking prompt corrective action to prevent overpayments from recurring.

Compliance Insights and Best Practices

OMIG identified the following areas within the compliance program reviews where providers had difficulty meeting the requirements in 2024:

- Performing an annual review of written policies.
- Conducting an annual review and update of the compliance committee charter.
- Maintaining a compliance program training plan.
- Publicizing compliance program information on the provider's website.
- Performing auditing and monitoring of all required risk areas identified.
- Performing exclusion checks for all affected individuals at least every 30 days.

Self-Disclosure Requirements

Applicable Regulations, Statutes, and Laws

OMIG held a webinar on August 26, 2025 entitled, “OMIG Self-Disclosure Requirements: Best Practices and Guidance”, which can be found here.

This presentation outlined the applicable citations surrounding self-disclosure.

For all Medicaid entities

- Affordable Care Act (ACA) of 2010 §6402
- Title 42 of the United States Code (USC) §1320a-7k(d)(1) & (2)
- Social Services Law (SOS) §363-d(6) & (7)
- Title 18 of the New York Code of Rules and Regulations (NYCRR) §521-3
- Title 18 of the New York Code of Rules and Regulations (NYCRR) §504

For Medicaid Managed Care Organizations

- Title 42 of the code of Federal Regulations (C.F.R.) § 438.608(d)(2)
- Title 18 of the New York Code of Rules and Regulations (NYCRR)
  - §521-2.4(f)
  - §521-2.4(h)
  - §521- 3.3(b)(5)
- Model Contract 3/1/2019
  - Section 18.5(a)(viii)(G)
  - Section 22.7(e)

Potential Penalties for Non-Compliance

- Social Services Law (SOS)
  - §363-d(6)(d)
  - §145-b(4)(D)(iii)
- State Finance Law (SFL) – New York False Claims Act

Medicaid Self-Disclosure Background

- Medicaid providers are required to report, return, and explain all overpayments within 60 days of identification.
- The OMIG created the self-disclosure processes to help Medicaid entities meet this requirement.
- Medicaid entities include Medicaid-enrolled providers, Medicaid Managed Care Plans (MMCP), and any other entity which bills or receives Medicaid funds.
- There is no overpayment dollar threshold for self-disclosure and there is a 6-year lookback period from the date of service.
- Voiding or adjusting claims does not satisfy the obligation to report and explain an identified overpayment.
- There are penalties for failing to self-disclose an identified Medicaid overpayment or not complying with the self-disclosure process.

Common Issues Identified

According to OMIG's presentation, commonly self-disclosed errors that led to a Medicaid overpayment included, but were not limited to:

- Errors identified by oversight agencies that require corrective action
- General billing errors
- Fraudulent behavior by employees
- Discovery of an employee on the Excluded Provider list
- General documentation errors
- Changes in billing systems which caused claims to be billed incorrectly

Damaged, Lost, or Destroyed Records

- Providers are **required** to maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records upon request.
- If a provider becomes aware that their records have been damaged, lost, or destroyed they are required to report that information as soon as practicable, but no later than 30 calendar days after discovery.

Additional details can be found Lost, Damaged, or Destroyed Records Reporting.

OMH Self-Disclosure Notification Protocol

OMH Self-Disclosure Notification Protocol

Providers licensed, certified, designated, or funded (either directly or indirectly) by OMH are required to notify OMH when they submit a Medicaid fee-for-service overpayment self-disclosure to OMIG using the full self-disclosure process.

OMH providers submitting a self-disclosure through the full self-disclosure process must report those overpayments to their respective OMH local field office and the OMH Medicaid compliance office at Compliance@omh.ny.gov .

Correspondence must include:

- Date the overpayment was determined
- Scope of the claims paid (i.e., date range of claims and amount of total overpayment)
- Program type and specific site(s) affected
- Explanation of the cause of the overpayment
- All corrective actions implemented to prevent further overpayments

Reasons for Provider Self-Disclosure

OMH requires providers to report any full self-disclosures submitted to the OMIG to their respective OMH local Field Office and the OMH Medicaid Compliance Office mailbox (Compliance@omh.ny.gov)

Below are some reasons providers have self-disclosed which also may impact an OMIG audit:

- Missing required documentation (including treatment plans)
- Late documentation
- Missing signatures on treatment plans
- Treatment plans signed by practitioners without the correct credentials
- Minimum time for services not met
- Services provided by an unlicensed provider

Coordination Between OMH and OMIG

OMH's External Audit Liaison

- OMH's external audit liaison works within the Bureau of Audit & Compliance Services and routinely interfaces with external entities such as the Office of the State Comptroller, the Office of the Medicaid Inspector General, and the Department of Health & Human Services Office of Inspector General for audits conducted of OMH's Central Office or facility operations.
- The liaison can be contacted at OMHAudit@omh.ny.gov.

Additional Resources

- Training: OMH & OMIG: Working Together to Support Quality and Compliance
- Training: Understanding OMIG Audit Protocols: What Providers Need to Know

Office of Mental Health

Capturing Impact: Effective Documentation for Group Services

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Senior Program Associate

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Agenda

01	Group Services: Core Principles
02	Structure of Group Documentation
03	Case Example
04	Common Errors & Key Takeaways
05	Questions & Answers

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Group Services - Definition

Group services are **structured, provider-facilitated interventions delivered to multiple individuals and or collaterals simultaneously** to address shared clinical or rehabilitative needs.

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Group Services - Core Principles

- Designed to address shared clinical or rehabilitative needs through evidence-based or evidence-informed interventions (e.g., psychotherapy, skills training, psychoeducation)
- Goal-directed and planned, with clear therapeutic intent and facilitation by qualified staff
- Individualized within a group context, each participant's needs, participation, and response are assessed and documented
- Linked to the service/treatment plan and supports progress toward identified goals
- Demonstrates clinical value and medical necessity for each participant, beyond attendance or participation alone

The Value of Group Services in Service Delivery

- Part of the comprehensive continuum of care
- Enhances and complements the full range of behavioral health services
- Reinforces skills and interventions introduced in individual sessions, providing opportunities for practice, peer learning, and real-time feedback
- Supports appropriate level and intensity of treatment
- Allows providers to adjust service intensity based on clinical need, serving as a step-up for additional support or a step-down to maintain progress and stability.
- Groups can be an engagement strategy and or discharge phase of an episode of care

Common Types of Behavioral Health Groups

- **Psychotherapy Groups**
  - Symptom reduction and emotional processing
  - Use clinical modalities (e.g., CBT, DBT)
- **Skills Training Groups**
  - Teach coping and functional skills
  - Structured, practice-focused
- **Psychoeducational Groups**
  - Provide education on conditions and treatment
  - Build awareness and self-management
- **Rehabilitation/Recovery Groups**
  - Support daily functioning and independence
  - Focus on recovery and community integration
- **Support Groups**
  - Promote peer support and shared experiences
  - Require clinical oversight and therapeutic intent
- **Collateral and Family Groups**
  - Include caregivers and natural supports
  - Provide education and communication strategies
  - Strengthen family and support involvement

Integrating Group Services into the Treatment/Service Plan

- **List Group as a Modality**
  - Group services must be explicitly identified on the treatment plan
- **Align with Existing Goals**
  - Group participation should directly support identified goals and objectives
- **Update When Needed**
  - If current goals do not align, revise the treatment plan and add appropriate goals

- **Track Progress Ongoing**
  - Document individual progress related to group participation at each group
- **Revise Plan as Goals Are Met and/or Evolve**
  - Update the treatment plan when goals are achieved or no longer clinically relevant

Program & Regulatory Requirements for Group Services

- Be aware that regulations differ across programs.
    - Including group size, duration, staff requirements.
- **Follow program-specific regulations**

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Structure of Group Documentation

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Group Note Components

- Administrative
- General group note
- Individual note

Administrative Component

- Service type (e.g., group psychotherapy)
- Date, duration, and location
- Name of Participants
- Group Topic
- Group Size
- Purpose (should reflect how it connects to treatment plan)
- Staff name, credentials, signature

General Group Note Component

- Summarizes overall group focus, interventions, and dynamics
- Describes what occurred during the session at the group level
- Does not include PHI or identify individual participants
- Applies to the entire group session

The Individualized Component

Clinical Elements

- Intervention(s) provided (what the provider did)
- Individualized response that should include
  - Individual's engagement and participation
  - Individual progress
  - How the individual interacted with the group and how the group reacted to them
  - Individual's response to interventions
- The Plan

Structure of Group Documentation

Key Distinction

General note = *what happened in the group*
Individual note = *what it meant for the person*

General Group Note

- Summarizes overall group focus, interventions, and dynamics
- Describes what occurred during the session at the group level
- Does not include PHI or identify individual participants
- Applies to the entire group session

Individualized Note (Per Participant)

- Documents each individual's participation, response, and progress
- Includes individual-specific observations and clinical impressions
- Clearly links to service/treatment goals and medical necessity
- Required for every participant in each session

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Case Example: Dana & Group

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Dana's Treatment Plan

- **Goal:** Learn and apply 1 to 2 emotional regulation skills weekly in session and practice within interpersonal relationships.
- **Objective:** Dana will practice 1 to 2 coping skills weekly and report back on their effectiveness during the following session, as evidenced by self-report and clinician observation, within 60 days.
- **Modality:** Weekly Individual Therapy & Group Therapy
- **Why Group:** Dana was referred to group by her individual therapist and is motivated to expand her coping skills, and the group provides an opportunity to learn new strategies, practice with peers, and receive real-time feedback in support of her goal.

Group Note Example: Admin Component

About This Group: A closed, skills-based psychotherapy group for adults experiencing difficulty managing emotional responses. The group uses a CBT-informed curriculum and meets weekly. Participation is linked to each member's treatment plan goal of improving emotional regulation and interpersonal functioning.

Today's Session Focus: Identifying emotional triggers and practicing grounding techniques

Service Type	Group Psychotherapy
Date	May 6, 2026
Start/End Time	10:00 AM – 11:00 AM (60 min)
Location	In-Person
Group Name	Emotional Regulation Skills Group
Session Number	Session 4 of 12
Group Topic	Identifying and Regulating Emotional Responses
Number of Attendees	6
Facilitator	Anna Baker, LCSW

Case example: General Group Note

- Today's session focused on identifying and managing emotional responses using a CBT approach. Members participated in a check-in to discuss current stressors and emotions.
- The facilitator introduced the ABC model to explore the connection between triggers, beliefs, and emotional responses. Members practiced applying the model to personal examples and discussed how changing unhelpful beliefs can impact emotions.
- Group members were engaged throughout the session and participated in discussion and skills practice.

Case example: Dana’s Individual Note

- Dana actively engaged in group and showed empathy to other group members. Dana demonstrated a strong understanding of the "window of tolerance" model as they shared how they have used grounding techniques in a work setting.
- The facilitator reflected back Dana's progress and supported her in identifying a between-session goal. Dana expressed pride in their progress and set a goal to use deep breathing during family interactions, which helps them work toward their goal of applying coping skills in her daily interpersonal relationships.
- Dana showed interest in practicing “window of tolerance” skills throughout the week and will share their experiences during the next group session.

Language Matters

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Best Practices in Documentation

Maintain Confidentiality

Never use names or identifiable information of other group members in an individual's note. Use generic terms (e.g., "another group member") to describe interactions.

Objectivity

Avoid judgmental language. Report only what is objectively observable. Focus on behavior and statements, not interpretations of character or intent.

Continuity

Write notes so that another provider has enough information to pick up where you left off. Include context, plan, and relevant clinical observations.

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Interventions and Language

Use Precise Verbs Example

- Facilitated practice of communication and emotional expression skills
- Supported client in exploring unhelpful thought patterns
- Collaborated with client to identify alternative perspectives and growth
- Validated client's emotional experience and affirmed their healing process

Descriptive Words for Participation

- Active listener
- Engaged
- Redirected by facilitator
- Minimally verbal
- Supportive of peers
- Verbally expressive
- Emotionally present
- Appeared withdrawn
- Attentive
- Participatory
- Receptive to feedback

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Common Errors & Key Takeaways

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Common Group Documentation Errors

- Copy/paste across participants
- Identical language for all group members
- Lack of linkage to individual goals
- Using identical or generic language for all group members
- Describing the activity without documenting the clinical intervention
- Missing the individual's response or progress

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Key Takeaways

- **Documentation Must Be Individualized:** Each participant needs their own note per session reflecting their unique participation, responses, and progress toward treatment goals.
- **Alignment with Treatment Plans:** Group participation must be listed as a treatment modality and directly tied to the client's identified goals and objectives.
- **Accurate Documentation:** Accurate documentation of duration, group size, and facilitator name and credentials is required to meet billing and regulatory standards.
- **Language Demonstrates Value:** Thoughtful language (e.g., "explored," "practiced," "connected") reflects the client's growth and demonstrates medical necessity.

Questions & Answers

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Lunch Break

Network with EHR Vendors:

Cantata Health Solutions
Medi-EHR
PrecisionCare

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AI INNOVATION IN BEHAVIORAL HEALTH

Enhancing Quality Documentation

Presenters:
Ciera Dudley, MSW, Senior Coordinator
Yvette Kelly, LMHC, Director of Strategy & Healthcare Innovation

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Disclaimer

This presentation was developed for **informational and educational purposes** only.

The content does **NOT** represent the official policy, position, or regulations of the New York State Office of Mental Health (OMH), the Office of Addiction Services and Supports (OASAS), or any other New York State agency.

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What are your thoughts around AI?

A. I am excited!
B. I see potential
C. I am worried
D. I feel overwhelmed

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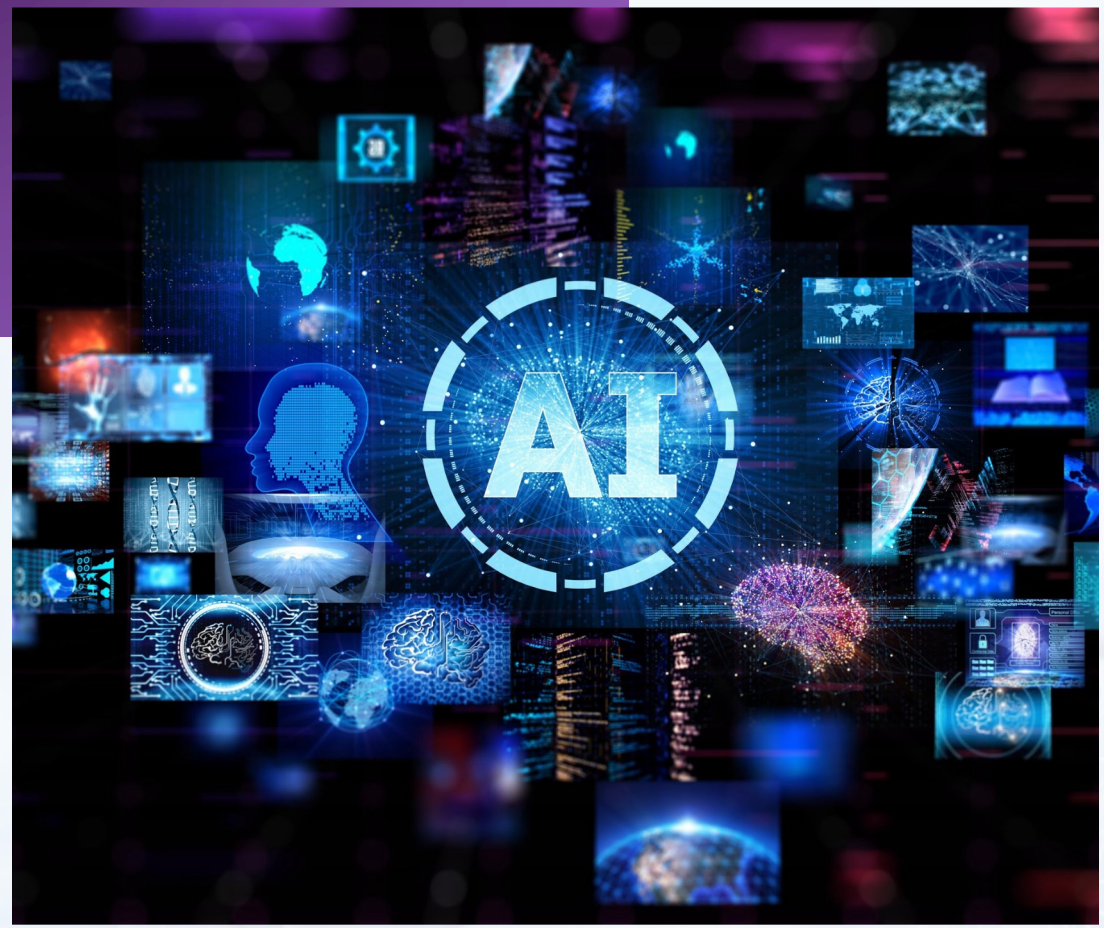

What is AI?

Artificial Intelligence (AI) is the ability of machines to mimic human intelligence—such as thinking, learning, solving problems, and making decisions.

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AI Adoption & Prevalence Statistics in US Healthcare

Healthcare

86% of health systems now using some form of AI technology.

Workforce

60% of the healthcare workforce now has access to AI tools—nearly double the rate from last year, when fewer than 35% reported access.

Organizations

Nearly 3 in 4 organizations plan to deploy autonomous AI within two years.

Participants

Over 1 in 3 individuals are using AI for health-related needs, including mental health and emotional support.

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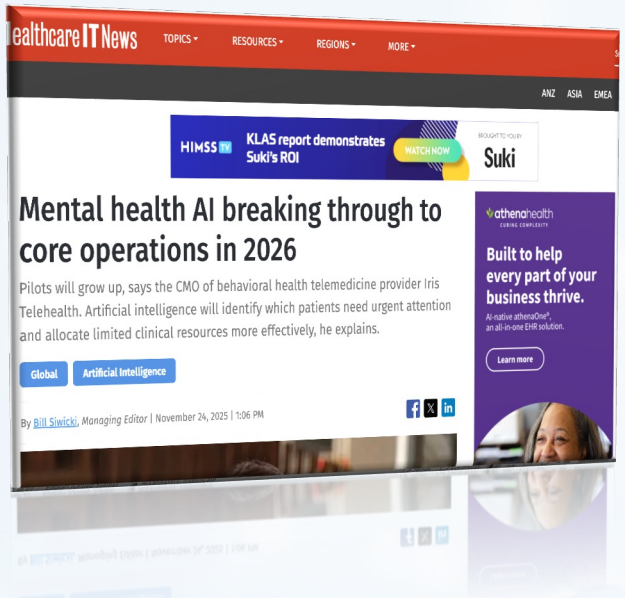
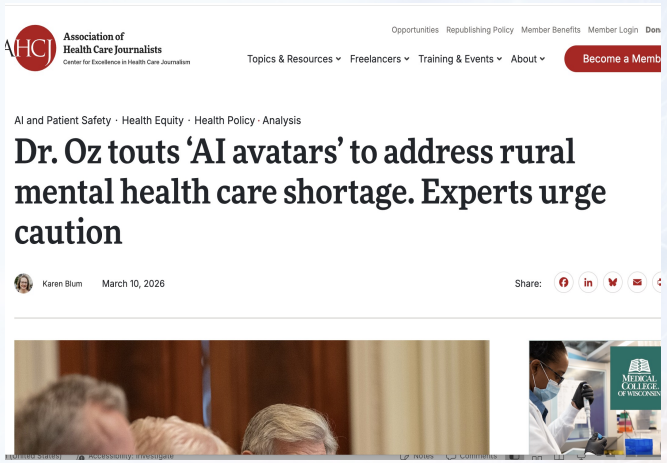
https://www.deloitte.com/us/en/what-we-do/capabilities/applied-artificial-intelligence/content/state-of-ai-in-the-enterprise.html





The Growing Conversation Around AI in Behavioral Health

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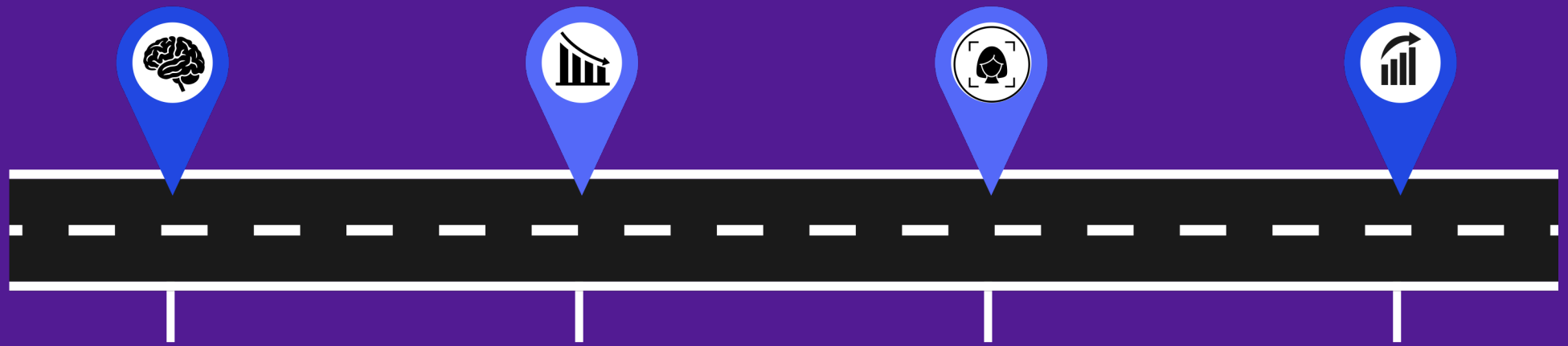
The Evolution of AI



01

1950 - 1956
The Conceptual Birth

Alan Turing proposes the “Imitation Game” and the Dartmouth workshop formally establishes AI as an academic discipline.

02

1970s - 1980s
The AI Winters

Finding and enthusiasm collapse as symbolic logic fails to solve complex, real-world problems.

03

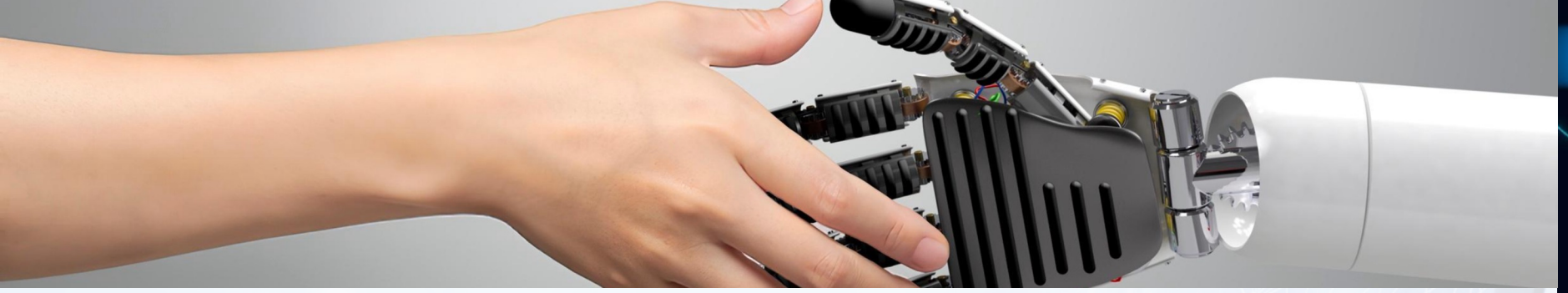
2012
The Connectionist Revolution

Deep learning achieves a massive 10% performance jump in image recognition, signaling the industrialization of AI.

04

2020s - Today
Foundation & Governance

Generative AI goes mainstream, shifting the focus from “can it work” to “how do we govern it”



“AI is no longer emerging—it is rapidly becoming standard practice”

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Where Is Your Organization Today?

How would you describe your organization's current relationship with AI?

A. We are actively using AI tools
B. We are exploring AI options
C. Leadership is discussing AI
D. Staff are independently experimenting with AI
E. We have not started discussing AI yet
F. As we know it AI is banned from agency use

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Why AI Now?

The Challenge

Behavioral health staff are experiencing **widespread burnout**

Organizations face **30–60% annual turnover**, disrupting continuity of care

Growing service demand continues to **outpace workforce capacity**

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Why AI Now?

Rising Administrative Demands

Demand for timely, high-quality documentation

Growing AI Maturity in healthcare

Advances in
Speech recognition
Natural language processing
Generative AI

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The Effect of Documentation Burden

Documentation burden is a primary driver of burnout

Excessive administrative demands increase emotional exhaustion

After-hours documentation contributes to fatigue and work-life imbalance

High documentation demands lead to turnover, particularly among early-career staff

Candidates are increasingly seeking roles with manageable documentation expectations and supportive technology

Clinicians increasingly seek organizations with streamlined workflows and supportive technology

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Documentation Burden: More Than an Efficiency Issue

Reducing documentation burden is not just an efficiency issue—it is a workforce sustainability strategy.

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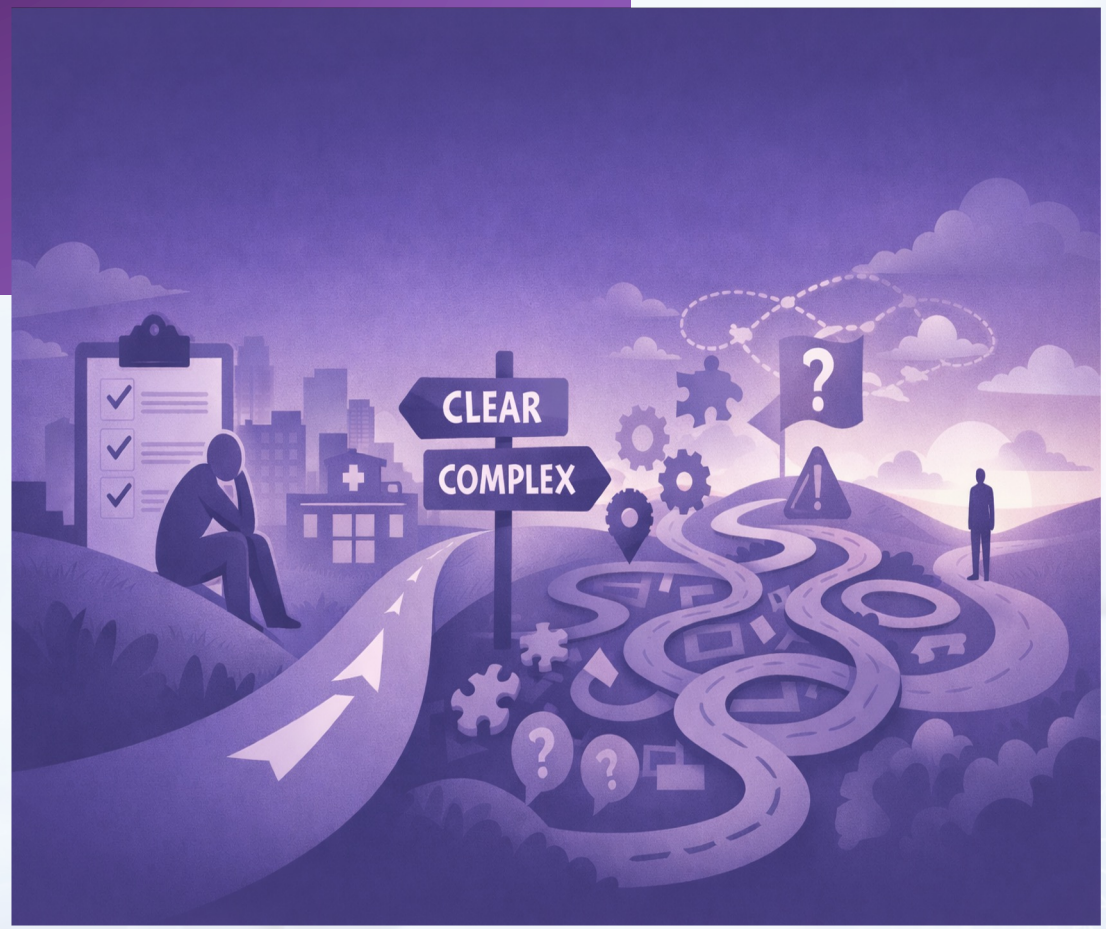

The need for change is clear, but the path forward is complex

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What are you most concerned about when it comes to AI in Documentation practices?

A. AI will replace clinical judgment
B. This will reduce the human connection
C. AI documentation will feel generic or inauthentic
D. AI could make errors that impact care or compliance
E. This prioritizes billing over care
F. Client data may not be secure
G. AI may introduce bias or inequities

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Common Concerns

Common Concerns	Reality in Practice
“AI will replace clinical judgment.”	AI supports, not replaces, clinical decision-making by assisting with documentation, pattern recognition, and efficiency. **Clinical judgment remains central.**
This will reduce the human connection.”	When used effectively, AI **reduces administrative burden,** allowing providers to spend more time in direct care and engagement.
“AI documentation will feel generic or inauthentic.”	Structured tools can enhance clarity and consistency, while **clinicians retain responsibility for tailoring language** to reflect the individual’s experience.
“AI could make errors that impact care or compliance.”	AI outputs require provider review positioning **AI as a drafting/support tool, not a final authority.** Oversight remains a core safeguard.
“This prioritizes billing over care.”	AI can strengthen the **“golden thread”** by helping align assessment, treatment planning, and progress note, supporting both clinical quality and compliance.
“Client data may not be secure.”	Many AI tools are being designed within **HIPAA-compliant environments** with increasing focus on data governance and privacy protections.
“AI may introduce bias or inequities.”	Bias is a valid concern, however, awareness is driving more intentional **design, oversight, and evaluation** of AI tools in healthcare.

AI-Driven Transformation of Documentation Practices

- Real-time or near-time documentation
- Structured, guided note-writing
- Automated summaries of clinical interactions
- Built-in prompts to support compliance

Types of AI Used in Behavioral Health Documentation

Most tools combine multiple capabilities

Automatic Speech recognition (ASR)

Converts spoken sessions into written notes

Ambient AI

Captures sessions and generates notes in real time

Generative LLM drafting

Drafts and summarizes clinical documentation

Template & Workflow Automation

Smart fields, auto-population, smart phrases

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Automatic Speech Recognition (ASR)

What it Does:

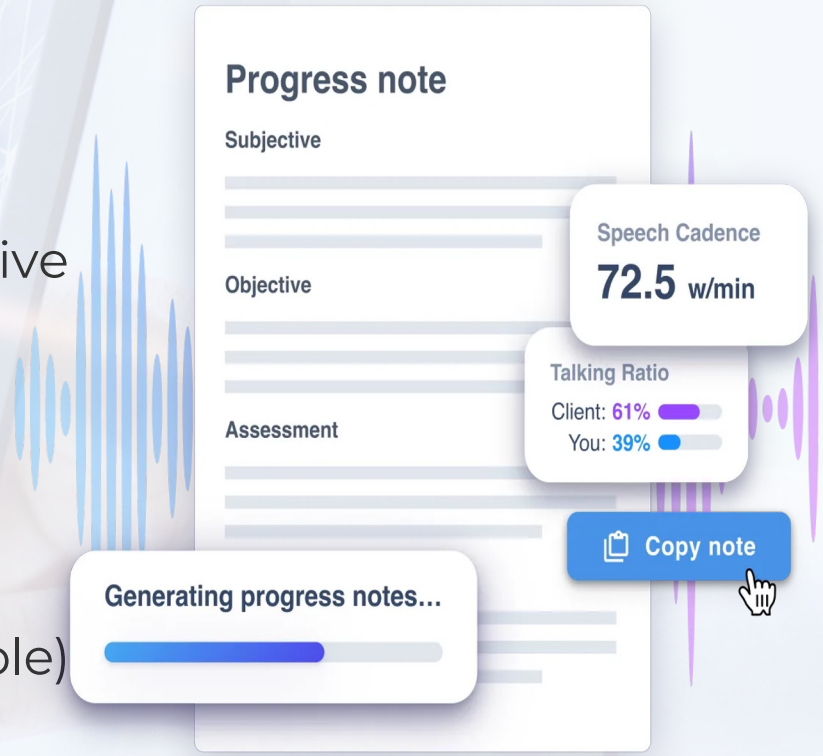
- Converts spoken language into written text

Applications:

- Real-time documentation during sessions (supports collaborative documentation)
- Post-session transcription of recordings
- Dictation for progress notes

Value:

- Supports timeliness (i.e., document as close to service as possible)



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Generative AI (Large Language Models-LLMs)

What it Does:

- Creates new, original content—such as text, images, music, or code—in response to user prompts.

Applications:

- Drafting progress notes from session inputs
- Summarizing sessions into clinically appropriate narratives
- Rewriting notes for clarity, compliance, and medical necessity
- Translating clinical content into person-centered language

Value:

- Enhances efficiency while standardizing documentation language

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Ambient Intelligence (AI)

What it Does:

- Captures clinical conversations in the background and automatically creates structured documentation.

Applications:

- Produces draft progress notes during sessions with minimal manual input
- Captures interventions, responses, and clinical language
- Supports collaborative documentation in real time

Value:

- Minimizes after session/hours documentation and enhances engagement during sessions

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Template & Workflow Automation

What It Does:

- Embeds standardized documentation templates within the EHR to guide clinicians in capturing required elements consistently
- Automates documentation workflows from service delivery through billing to ensure completeness and compliance

Applications:

- Required fields (e.g., intervention, response, duration, participants)
- Drop-downs and checkboxes
- Smart phrases/macros for consistent clinical language
- Auto-population from assessments, treatment plans, or prior documentation

Value:

- Standardizes documentation across providers and programs
- Improves clarity and consistency, especially for staff needing more structure
- Strengthens audit readiness
- Directly supports accurate and timely reimbursement

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Why It Matters

Ethics in AI

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Code of Ethics for AI-Assisted Clinical Practice

Core Ethical Principles

- Accountability - Clinician makes all final decisions
- Transparency - Disclose AI use + its limitations
- Confidentiality - Protect patient data (HIPAA-compliant)
- Bias Awareness - Monitor for fairness across populations
- Clinical Judgment - Clinician overrides AI suggestions
- Informed Consent - Individuals understand and agree to AI involvement
- Ongoing Oversight - Regular review, validation, and updates

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Human Connection & Ethical Care

AI does not replace the human connection between providers and participants. Instead, it can enhance this connection by removing barriers, such as administrative burdens and time constraints, allowing providers to focus more fully on meaningful interactions with individuals.

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When Done Right: AI is a Partner

- Reduces burnout & admin time
- Augments decision support
- Expands access and personalization
- Improves operational efficiency

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The Future

- Technology continues to advance and enhance our livelihood
- Seek to understand and utilize AI when it increases efficiency and improves outcomes
- Responsibility to ensure our technology never exceeds our humanity

Generative Artificial Intelligence (Gen AI) in Behavioral Health OMH Provider Survey

OMH invites you to participate in a brief, confidential survey regarding the use of Artificial Intelligence tools in your organization.

This survey asks if people at your organization use AI tools for work, such as within existing electronic health record systems, billing processes, appointment scheduling, staff training, or for clinical support. Our goal is to understand policies and safeguards in AI use, and any concerns or caution in using AI tools.

This survey takes about 10 to 15 minutes to complete and will be available until Friday, June 5, 2026. All responses are confidential — the survey is anonymous, and responses will not be used for compliance actions or penalties against your organization. Your responses will help OMH develop guidance and support to ensure these tools are used safely and responsibly across our provider network. There is optional space to add contact information should you want OMH to reach out to you on this topic.

Please find the survey here: Generative Artificial Intelligence (Gen AI) in Behavioral Health OMH Provider Survey

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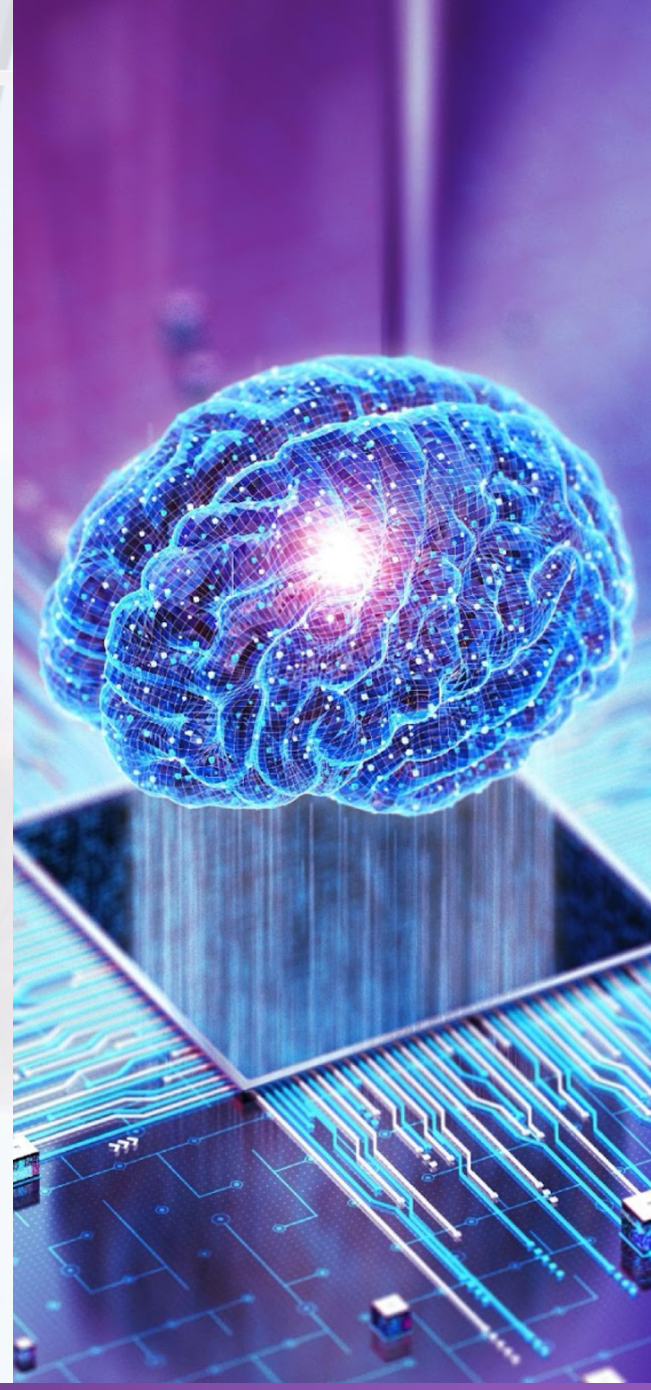
Questions



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Building a Community of Practice

Rayna Wang, LCSW
Assistant Director, Healthcare Innovation

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“

Documentation is an extension of the care we provide.

It is a tool through which we capture the stories of individuals and families.

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Shifting Toward a Culture of Learning

Compliance-Only Culture

- Are conversations on documentation focused solely on timeliness, audit risk, and completing “all” of the fields?
- Are staff embarrassed or afraid to ask questions about documentation and note-writing, after onboarding/training?
- Are you seeing the same sentences and interventions copy and pasted across multiple people’s notes?
- Is Quality Assurance (QA) seen and felt as a punitive management technique?

Learning Culture

- Are staff receiving coaching and feedback regularly?
- Do team leaders share their own clinical work and notes?
- Are there tools and activities for co-learning and peer-to-peer learning?
- Do staff feel comfortable being vulnerable and admitting that they would like support on how to write notes and treatment plans?
- Is documentation seen as a tool to capture individuals’ stories and recovery journeys?

Pillars of Strong Documentation

Empathy

Precision

Continuity

Pillars of Strong Documentation

Empathy

Convey respect and dignity of the individual and capture the individual's voice and recovery journey

Skillset: Use person-centered language and strengths-based framing of situations

Precision

Distill complex concepts and behaviors to show medical necessity and supports provided

Skillset: Write succinctly to incorporate professional knowledge in the context of the specific interaction

Continuity

Maintain the "golden thread" that connects pieces of documentation into a cohesive narrative

Skillset: Directly identify connections between specific interaction and long term goals and objectives of treatment

Using Person Centered Language to Describe Progress

Ling is a 25-year-old with major depression. She shared her goal is to make new friends at her new workplace. Services include weekly peer support and individual sessions.

Original:

- Client failed to attend peer support group this week and did not follow through on goal of calling a friend. Thus, no progress made towards treatment goals.
- Client sat in silence for the majority of the session and made no eye contact with clinician.
- Clinician provided psychoeducation to the client on the importance of verbalizing her feelings.

Revision:

Ling was unable to attend peer support group this week and did not reach out to a friend as planned.

She was silent during session and looked down at the floor, with her shoulders hunched over. Clinician allowed space for silence and asked Ling if she would prefer to write/draw out her feelings, or if she would like to talk about them. Ling chose to draw and write down a few words and said she would like to sit in silence because “there’s a lot going on in my head right now.”

Clinician normalized silence as a modality for processing feelings, and clinician used body language to provide a supportive presence, staying attuned to Ling’s posture and affect. When checking in at the end of the session, Ling said she was able to organize her thoughts a bit more and that she would share more during the next session about why she didn’t attend peer group this week.

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LANGUAGE MATTERS

STIGMATIZING LANGUAGE	WHY IT'S PROBLEMATIC	PERSON CENTERED ALTERNATIVE
Manipulative	Labels behavior negatively without considering coping strategies or underlying needs	Seeking to have needs met during; demonstrating survival-based behavior; is expressing their needs and advocating for themselves; is learning effective communication strategies
Maladaptive	Implies that a person's behavior is "wrong" or "faulty," rather than viewing it as a functional attempt to cope with difficult circumstances	Functional/historical coping mechanism, survival response, attempts to manage overwhelming distress, self-soothing or self-regulating behaviors, coping strategies that no longer serve the individual's current goals; behavior used to communicate an unmet need, response to environmental stressors, attempt to seek safety or connection; behavior that interferes with individual's desired quality of life or achieving specific objectives; barrier to the person's recovery priorities
Non-Compliant with treatment or medication; Refused services	Implies willful defiance, can sound accusatory; may not capture the individual's reasoning or informed choice; may not capture the barriers to care.	Considering other wellness strategies; is not in agreement with; prefers alternative strategies; declined the service/medication/intervention; currently not interested in this option.

LANGUAGE MATTERS

STIGMATIZING LANGUAGE	WHY IT'S PROBLEMATIC	PERSON CENTERED ALTERNATIVE
Resistant	Suggests blame on the person instead of recognizing ambivalence or systemic barriers.	Ambivalent; Hesitant; Uncertain; Engaged in recovery planning
Failed at completing the program	Implies personal failure rather than a treatment mismatch or system issue.	Did not achieve desired outcomes with this approach; Is working on improving this skill
Exhibits Poor Functioning	Deficit focused, vague and judgmental measure of functioning; implies unchangeable state	Has difficulty with consistently completing; struggles in this specific context due to their symptoms of; is learning to
Is schizophrenic, is bipolar, is psychotic	Labels or defines the individual by their diagnosis; dehumanizing	Is living with schizophrenia; is diagnosed with bipolar disorder; Is experiencing symptoms of psychosis

Tailor Practice to Documentation Skills

Questions When Reviewing Your Team's Documentation	Relevant Workbook
Are the recovery goals of the individual captured appropriately and relevant objectives also meet SMART criteria (specific, measurable, action oriented, relevant, and time-bound)?	**Developing Effective Goals**
Is the progress note concise or is there a lot of unnecessary detail included that is not relevant to the treatment goals?	**What's In and What's Out**
Are there clear descriptions for the support and services provided, that align with the provider's scope of services?	**Progress Note: Sample Action Statements**
If the progress note were shown to the individual, would they feel respected?	**Avoiding Assumptions and Judgments; Using Strengths-Based Language**
Are progress notes specific and customized to the individual, or are they "copy and pasted" from other individuals' records with minimal revisions to pronouns, names, or other identifiers? Would these be a red flag for an auditor?	**Proofreading Progress Notes**
Do progress notes about interactions with "collaterals" explain why the interaction is relevant, the service provided, the response to the service, and next steps?	**Documenting Service Encounters with Others**
Do progress notes about interactions that veer away from the plan (e.g., crisis services) mention the original plan, information about the crisis, the intervention provided, the response to the service, and next steps, including any necessary care coordination or other follow-up?	**Documenting Unexpected Needs**

Who Is Involved In The Documentation Process?

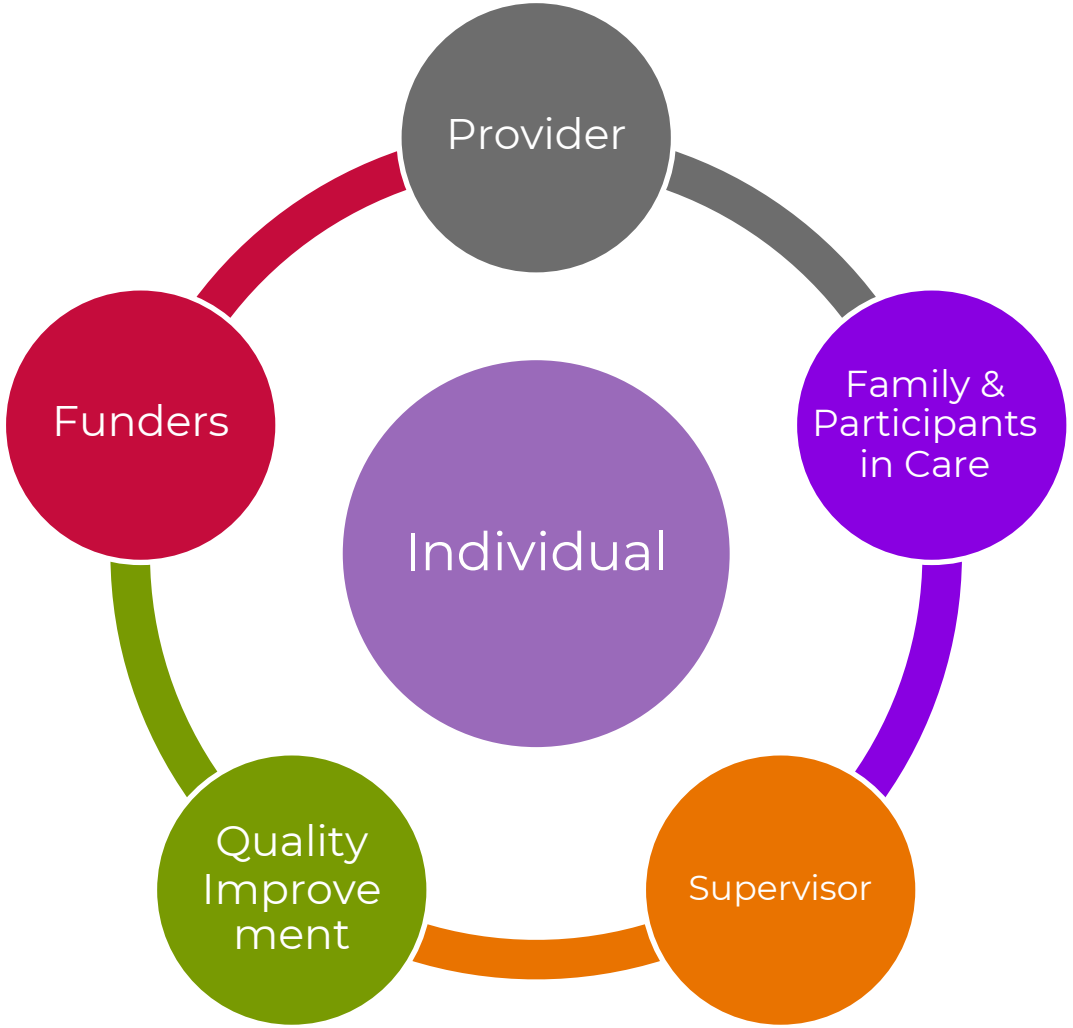

Table Discussions

Introduce yourself and your role, then share with each other:

1 strength

What is one documentation-related skill that your team or colleagues are great at? Be proud of this!

1 skill to improve

What is 1 documentation-related skill that keeps you up at night and could benefit from further practice?

(Examples: person centered language, identifying goals/objectives, ability to describe clinical interventions, comfort level with writing, using brief and succinct language, deciding which details to include or exclude, etc.)

1 strategy

What is 1 strategy or suggestion you could bring back to your team to help build a community of practice at your agency?

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Designate one person from your table to share-out to the large group at the end.

Report-Out on Strategies

What strategies or suggestions will you bring back to your team to help build a community of practice at your agency?

Strategies

- Reframe documentation-related meetings to emphasize a culture of “learning” rather than compliance
  - Reflection question: Who do you need buy-in from, for the culture to shift?
- Model vulnerability as a leader by sharing a documentation-related skill that you are learning too
- Embed documentation in supervision and team meetings
  - Individual review, and/or anonymous peer to peer review exercises
  - Utilize workbooks and resources
  - Design your own workbooks and sample documentation for your agency
  - Reflection question: Who do you need buy-in from, to create time and space for professional development and skill building?
- Talk with your peers and other team leaders about strategies you’ve used for your teams

Example: Progress Note Self Check List

Self Checklist for Progress Notes (customize for yourself)
❑ Use person-centered language to capture the individual's experiences, responses, preferences, and decisions
❑ Described in detail the service provided (e.g. the modality and specific technique) and how it connects to supporting the individual's objectives and goals listed in the ISP/IRP
❑ Signed and dated
❑ [Fill in]: _____
❑ [Fill in]: _____

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> ***Documentation is a professional craft built over time and requires consistent training, supportive supervision, and an agency-wide culture of practice***

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Questions?

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Resources

- Documentation Done Right Workbook Series is available for free on our website with a CTAC MCTAC Login

- To contact MCTAC: mctac.info@nyu.edu

Feedback Survey

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