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NATIONAL COUNCIL FOR BEHAVIORAL HEALTH  
2015 MAI-COC GRANTEE VIRTUAL MEETING  
MASTERING CONCURRENT AND COLLABORATIVE DOCUMENTATION, MTM  
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(For 20 minutes, standing by, trying to get access to Adobe  
Connect for audio, was given no dial-in number and told Adobe  
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breakout room 3, not 4. Finally received a dial-in number for  
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>> You will have a better understanding of what I mean.  
Let's talk about how do you do a assessment collaboratively. A  
lot of people are doing this already. Some people are probably  
sitting here saying, this is something our organization does,  
but maybe the treatment plans in progress, the notes are things  
we are still working on. We will get to that, I promise.

If we sit down with a client, and we introduce to the client  
that we are going to write an assessment together today, because  
I want to make sure that what I'm hearing you say is accurately  
representing what you are telling me, I want to make sure that  
you are a part of the process. The feedback we got from this is  
that clients feel less judged, they feel part of the process,  
they are not fearful of what we are thinking of them, because we  
are including them in that process. How do we do that?

I always make the joke that I'm a terrible typier. Never  
been my strength. When I go to do collaborative documentation  
and I do a assessment, my approach is ask the client a question,  
what brought you here today so that I can understand their

presenting problem. I'm going to listen to them and then I'm going to turn and I'm going to start typing and I'm going to say this is what I heard you say. I'm going to start writing what I heard them say. I'm going to have an opportunity to, they will have a opportunity to correct me or agree with me and make sure that I'm getting it right.

There is other staff that are fantastic typers and they can give eye contact and type at the same time. If that happens to be you or one of your staff, I strongly encourage, let the client read it as you are typing it or review what you just typed. This is what I wrote down, this is what I heard, did I get that right. It's a different experience for our clients. Think about how we go to the doctor today. I've had so many experiences lately, where a nurse comes in and takes notes, and then as I'm leaving I get this note about what happened today and I read some of what the nurse wrote, and she got information wrong. It's frustrating because she never checked with me, never said is that what you meant or is that what you said? She is getting it wrong.

I know that when I was not doing collaborative documentation, that I'm sure I was getting things wrong as well. This is a way to ensure accuracy.

With diagnosis this is a area people say, you can't do the diagnosis collaboratively with the client. I will tell you that there are people that are doing diagnosis collaboratively with the client, that based on the information they gathered, they feel they can do that. Other people are not.

But there is one thing we absolutely can do, even if we don't complete the diagnostic formulation, and that is, we can write down the symptoms. We can understand what symptoms the client has. We can understand if there is any triggers to those symptoms. We can understand how those triggers are impacting the client's functioning or how those symptoms are impacting their functioning. Those are all things we can jot down so that we can complete our diagnosis formulation.

If I can't complete it with them, I let them know that this is something I will be finishing after you leave today, but the first thing we can do next week if you would like is review what I wrote.

The clinical summary, when we are working on the clinical summary.

(coughing) Excuse me.

This is something that we really struggle with, staff feel this is where I write my impressions, what I saw. But again, this is about what we talked about today. So I can turn to the client and say to them, we need to summarize what we have discussed today. And this is one of those times where that

agree to disagree comes in handy, because I might have made some observations during our time, and I bring those up and the client doesn't always agree with them and that's okay. Again we can model for them at that point and say to them, I'm so glad you felt comfortable telling me that you see it differently than I did.

It doesn't mean I'm not going to include what I felt I saw, but I'm also going to include your perspective.

Or, if somebody doesn't understand something I'm saying, again, can I shift my language in a way that would help them understand better.

But this can and should be done with our clients. Finally, our assessed need. Remember this is what is going to help us link to our treatment plan. That being said, we want to make sure that we are developing an assessed need that our client understands, and we need to remember that there may be some things that we feel our client needs to work on. But that they are not interested in working on right now. So we might identify it as a need, but we are going to need to include in that, that this is something the client isn't interested in working on right now.

But there is different approaches we can take. Developing some form of a statement, of an assessed need, often I've heard people using things like, we go back to our diagnosis and we talk about what were those primary symptoms that are affecting the client the most and developing statement that way. Or saying something like the areas that we have identified that we should work on together, are ...

One way or another we want to make sure that they are aware of what the needs are or they are helping us identify those. It shouldn't just be coming from us. Because what we are going to do is once we have developed those needs, we are going to go to the treatment plan. With the treatment plan ...(pause).

I'm sorry. With the treatment plan, what we are going to be doing is taking that assessed need and turning it into a goal, meaning that a goal is a general statement. Remember, the goal is that general statement that is going to help us identify what we want things to look like. We are going to take that need and we are going to turn it around.

If a client is telling us that they need to not feel sad all the time, if they are saying, I need to be able to get a job, whatever it is that they are identifying that need as, we need to turn it around and say what do we want that to look like?

And that is going to be (Beep) our goal.

(coughing).

I help my clients understand this by using the staircase, thinking about that goal being at the top of the staircase. And

then what we are going to do is we are going to talk about the objectives. The objectives are the steps that our clients are going to take, in order to be able to climb up to reach that goal.

When we write these objectives with our client, what do we need to do? We need to ensure that it is apparent to the client meaning that it's in the client's language, that they understand what we mean, that it makes sense to them, that it's meaningful to them, that it can be achieved in a reasonable amount of time. Sometimes a reasonable amount of time is only three months. Sometimes we need to make little steps for our clients, not real big steps. We don't want them skipping stairs along the way.

What is the first step they need to take? If we have a client that has absolutely no coping skills, we are not going to set an objective that they have three. We want to start with them having one, that they can really utilize and understand how to use.

The other thing is, we want to make sure that those objectives can be assessed in an objective way. Remember these are little outcomes. What is the first outcome we want to achieve? What is the second outcome we want to achieve to get to that goal?

Next is the interventions. A lot of people will say, I write my goals and I write my objectives with my clients, but then I go back and do the interventions and services after they have left.

If we don't write our interventions with our client, then they don't understand, I'm not just talking about you (Beep) needing to do a, work towards an objective, but I'm going to be walking up that staircase with you. I'm going to be the one that is going to be assisting and supporting you in achieving those outcomes that you are striving for.

You will not be alone in this process. With services, think about how many times we tell a client that we really think they would benefit from weekly therapy, and then they don't show. But if we start writing the services that we are recommending and we ask the question of, is this something you can commit to, is this something that you are able to do, to come in every week. Maybe they will say yes, and maybe they will say no.

If they say no, then I'm going to say, what do you think you can commit to? I can come every other week. Great. I just want you to know, if we can meet together for the next four weeks, we can get started in your treatment plan, make sure that we have everything working the way you need to, get you in to see the doctor, if that is what you want, or we can do that over the next eight weeks.

Oftentimes, the response I get from a client is, I thought

you were thinking I had to meet with you forever, every week. But when you think it's four weeks, I can make that happen. All of a sudden just by taking the time to help them see, I'm not asking for even a three-month commitment, can you make a one-month commitment? Then we will discuss at the end of that month what is going to be best for us? It's really important for us to remember that treatment plans set the stage for collaborative documentation. If we don't have a useful treatment plan, then we are not going to be able to have that golden thread. We are not going to be able to take that assess me, turn it into a goal, have those objectives and then write a progress note that is going to be reflective of that.

That is why having that useful treatment plan is going to allow us and make collaborative documentation of progress notes so much easier.

This is also going to help us with compliance.

Very often, when people aren't doing collaborative documentation, what we have learned is, is that they go and they do their therapy session, and then later they try to figure out how that fit into the treatment plan, and very vague goals that they have written.

But if we are using that treatment plan in every session and identifying this is what we are working towards, then we are going to improve in our compliance.

It's also going to help with engagement. Because as we are writing progress notes and as we are assessing the progress or identifying, this is an area that isn't going well, we may need to make a change here, identify that with them. Update the treatment plan if it needs to. Don't wait until treatment plan review time.

If the objectives are not being met we need to ask ourselves, what do we need to do to change it? What is the key to completing progress notes?

First, we need to be aware of the treatment goals and objectives. We need to start every session by reviewing the previous week's note. We will not be reviewing the entire note. We are not looking to rehash everything we did last week. But oftentimes what we review is the plan section, because in the end of the therapy note we write a plan of action. Let's review and see how we are doing then.

Many people will also after they reviewed the previous week's plan session, complete a mental status at the beginning of the session. Not everybody does that. Some people say that helps. Other people say no, I do everything at the end.

So you review the previous week's note, you may or may not do the mental status and then you have your therapy session as you always would.

Until you get to wrap-up time, and we all wrap up our sessions. In those last ten minutes of our therapy session, instead of just verbally wrapping up and trying to start transitioning the client out, we are going to verbally and visually wrap up. We are going to document together about what we are working on, about what goal we were addressing, about what was helpful, about maybe what the client needs differently.

Then we are going to write that plan section. That plan section is a very powerful part of our progress note. It's one a lot of us miss when we do post-documentation. When I was doing post, documentation, my plan usually said we will meet with client in one week to continue working on treatment goals or we will meet with client in two weeks to continue working on treatment goal. It didn't mean anything. It didn't mean anything to me. It was a way to write it so I could get to the next note that I had to write.

But if we do a collaborative plan, then if there is something we want the client to work on, if there is a task we are asking them to do, if there is a skill they are going to try to use, if there is a homework assignment that I'm giving them, guess what? I'm going to write it on that plan.

Then the second thing is what if the client is asking me to do something on their behalf, make a phone call, find a resource, bring in a book for them, whatever it is, I'm going to write that down in the plan also because not only do I want to hold my client accountable, I want them to have the opportunity to hold me accountable. And guess what? I make mistakes.

There may be times where I said I was going to do something and maybe I tried and then I didn't connect with the person and I forgot and I didn't follow through. It's going to happen, but I can acknowledge it. I can say to the client I said I was going do this, I started it, I didn't follow through, I'm putting it in the plan again and setting myself a reminder right now.

The last thing is, is there something that we need to make sure we cover at the beginning of the next session? Maybe it's something that we were talking about today, that the client wants to make sure we follow up on, maybe it's that we notice the treatment plan review is coming due, so I want my client to know that is how we are going to start the next session.

(coughing).

Maybe it's that we are getting to the end of the session, and all of a sudden the client brought up a new topic they absolutely feel they have to discuss, but we are in our wrap-up time. Rather than starting on a new topic that we are not going to have time to address, I tell my client, we are going the write that down as the first thing we will discuss at the

beginning of the next session.

I will be honest, the first time I did that with some of my clients, it didn't go over well. They wanted to see if she really going to follow through with this, she is saying she is not going the address it but what if I tell her I'm going the kill myself, then what is she going to do? I had clients that would test those limits. But in the end it created a great structure, we had a beginning of the session, middle of the session and end of every session. It became predictable for our clients.

What do we write in a progress note? Most progress notes, no matter what the progress note looks like, we are all gathering the same information. We are going to include, if there is any new salient information provided by the client, we are going to complete a mental status, we are going the identify what those goals and objectives are that we focused on today.

I'm going to identify what interventions I was providing to try to support this client. Then I'm going to ask the client for a response on that. What we did today was it helpful? Is it something that you are finding to be useful? Do you have a reaction to how we did, what we worked on today? Giving them an opportunity to give feedback, to give a response, to talk about what is working or not working for them.

Then we are going to identify the progress they are making towards the goals and objectives. We are also going to notice sometimes that we are not making progress, and we are going to need to look at why is that happening? Are we regressing? Did we make the treatment goals or objectives too challenging? But we want to be able to assess that, and then we are going the write that plan. What are you going the do, what am I going to do and what are we going to do together.

When we transition to collaborative documentation, there are important things to take note of. One is just to remember that we need to do as much as we can. You don't want to go into the situation of thinking, I have to be able to do it all, or I can't do it at all, because then we will fail. But the goal of collaborative documentation is to be able to transition to a point that we can do it 90 to 93 percent of the time.

So that only 10 percent of the time will we need documentation time instead of right now, when most of us are still in a situation where we are having to do most of our documentation later.

But in making this transition, we have to think about it as, where can I start? What can I do? Sometimes it's going to be driven by the client. It is going to be driven by their symptoms, driven by how much they can tolerate, because some clients hear that we want to do this and they want to know

everything we are writing and they are excited about it. Then we are going to have those clients that might not be so excited. We might have a paranoid client that, oh, no, I don't -- no, no, they don't want any part of it. That's okay. They might fall under that 7 to 10 percent.

If I go to do a progress note with a client for the first time, and I talk about collaborative documentation, I might not get the whole note done. I might just get the plan done. That is okay, that is a start. That is doing as much as you could that day. Maybe I have a resistant client. Maybe I have somebody not so sure I want to do this.

If that is the case, that is okay too. Tell them or ask them, would it be okay if we just write the plan? I'm trying to write a plan with all of my clients to make sure that we are clear on what we are walking away with today, and is there anything we need to cover next time.

Then at the beginning of the next session, what I do is, I say I'd like to show you the note I wrote after you left. I would like you to understand where I could really use your help. When you are making the transition, just like we set treatment plans with our clients, I encourage you as an individual to create a treatment plan for yourself. Set a goal. Your goal is to be able to do collaborative documentation 90 to 93 percent of the time. That is the top of your staircase.

How are we going to get there? That is what we want to focus on. How are we going to get there? What steps do I need to take? Maybe I look at my caseload and I pick one client a day, maybe I say I'm going to try it with everybody, but I'm only going to do one section of the note. One of the things I always encourage is that if you get a brand-new client, that with that brand-new client you jump in with both feet, you do a assessment, you do a treatment plan, you do progress notes, because then they are going to know this is how it's done. You are not going to make a change with them later. Even though you think as I'm going through it, they are not going to experience it that way.

It's going to be important that you think about what support do I need or what support does my organization or my staff need, in making this change. Make sure you are having dialogue with staff about how is it going, what is working, what is not working, problem solving through what is not working. The other thing is, is that we need to remember not to let exceptions become the rule.

What I mean by that is that I have had staff that have said, I tried it with an ADHD client and it was a horrible disaster. So if any of my clients have ADHD, I do not do collaborative documentation. What is the disservice you are doing to all the

other clients you encounter that have ADHD if you decide to make that a rule, because some ADHD clients absolutely respond wonderfully to this, because it's the structure and predictability that they need.

We have to be careful, we never want to create those rules.

How do we make this transition with clients? How do we introduce collaborative documentation to a client? What I encourage is for you to think about what you want to say ahead of time. Develop a script for yourself. Not a script you are going to read but the highlighted points of what you want to make sure you say when you talk to the client.

Remember to keep some things in mind, like this is your note. This is your chart. This is your care. Here at our agency, we are transitioning to writing progress notes with our clients, because it is allowing us to be more effective in ensuring that the work we are doing together is helping you.

Something like that, that is helping them understand why we are making a change, if it's an existing client. If it's a new client, we are going to say this is how our agency does it, we will introduce a assessment, and how we do it together, what a treatment plan is and how, why we do it together, and then we are going to introduce that progress note and do that together too.

We are going to make sure that what they hear is I want to make sure that what I'm writing is accurate, that I'm understanding you accurately, that you are understanding what we are doing. I want your opinion. I want your feedback. This is about your care.

I want to make sure that each service that we are providing is working for you or if it's not working I want to be aware of that. Those are types of things we want to say to our clients, to better understand. Some general strategies that I want you to be aware of, is that when we have a client and we are documenting, whether we are documenting collaboratively or not, we should be assuming at all times that our client will read the document at some point.

A lot of the points that I've made today about language and having it be something that the client understands, those are all things that we should be doing, even if you weren't doing collaborative documentation, because it is our clients' charts. They do have a right to it. They could read it at some point.

If we start to think about it that way, collaborative documentation definitely becomes easier. When we are documenting, if a client wants to see what we are documenting, it's no secret. Let them see. I've had some organizations that will turn their computer and I've had some organizations that literally had two screens on their desk so that the client could

see it easily. We have to remember that we do have some clients that might not be able to read, and so we need to be aware of that, and again, might want to do more of rephrasing. This is what I heard you say, so that we don't put them in that uncomfortable situation.

Remember that agree to disagree. It's going to happen. It already happens. I see it one way, they see it another. When we often do though is don't share those observations because we are not writing with them. We are not being transparent about it. But all of those are opportunities. The first time you have somebody say, that's not right, you've got it wrong, help me understand, what did I get wrong? If they are able to help me see it differently and maybe I did misunderstand something, great.

If they see it one way and I still see it the way that I identified, again, I'm going to say thank you, thank you for telling me how you see it differently than I did. Let me write down your perspective as well.

Remember, do as much as you can. Don't go into it saying, I couldn't get the whole note done so I'm not doing it well. I was speaking to a nurse just today, who said, yeah, I don't think I'm doing this very well, and then she started rattling on all the ways she was doing collaborative documentation and how she had several clients that were responding to the structure, because they are very tangential and they get off track, and this was the one thing that was helping her help them stay on task.

Just hold on to doing as much as you can and not worrying about what you can't do.

Identify the aspects of the document that are most important for you to do collaboratively. For example, when you first start doing a progress note together, you might not get the whole note done. But what are those things you want to make sure you do together? Might just be the plan the first time. Might be the goals and objectives. Might be the client's response.

You need to identify what you think are the most important areas. Treatment plan, it might be starting with goals and objectives, but working towards including the rest of the document, the interventions and services.

Then stay with clients that you think will be receptive. Don't start with your hardest client. Start with the client maybe that you have a relationship with, that you think would positively respond to this. And/or like I said before, a brand-new client, because those brand-new clients aren't going to know any different.

(coughing).

I flew through that as fast as I could, because I wanted to make sure that if people had questions, that they were able to answer them.

>> From National Council, to jump on again, for anybody who missed the announcement at the beginning, you are currently muted, but if you would like to ask a question since we are on a smaller group here, you can unmute your line by hitting star 6 and asking a question. You may type any questions you have into the chat box. (pause).

Looks like people maybe are shy. I don't know if there are common questions you are thinking of or anything else you want to cover, Catherine, right now, while people are still thinking of questions.

>> KATHERINE HIRSCH: One of the questions I often get is what if the client says I don't want to document during a session? That is a real concern for people. Again I think what is important to keep in mind with that is that, if a client says, I don't want to do this, usually it's because it's unfamiliar, they are concerned. I've had some staff come back to me and say my client said they didn't want to know what I thought of them, which concerns me, when I think about that, because we certainly don't want our clients leaving worrying about what we are thinking of them.

The approach I talked about of maybe asking if you can do the plan section, and then showing them the note the next time, to ease them into it and help them understand what that process might be, and just taking it slow with them, versus just saying, you don't want to, we don't have to. But really, taking the approach of emphasizing the fact that this is something that I really value, I want your input, we really believe that this is best for your treatment to ensure that we are working towards the same things and understanding the same things, and just helping them ease into trying something, because like I said, usually their resistance is because it's an unknown.

The other thing is, what if a client says something, that they do not want documented. With that, my response is language. There will be a time that clients tell you something, and they don't want you to repeat it. Sometimes it's things we shouldn't repeat. Sometimes, a lot of the time, it doesn't necessarily have to be in the chart.

For example, and I hope I don't offend anybody by this but it's something that usually really helps people kind of grasp what I mean by this. If I have a client that comes in and is very emotionally distraught, maybe even suicidal, and reports that she had an abortion. It's a very upsetting thing for her, maybe regret or remorse, whatever the emotions are, writing that down is not what I need to include in the chart.

In fact, a State's Attorney will tell you that you are not the one that provided that, so you should not put that in the chart. What I'm going to write instead is that the client made a personal choice and is having an intense emotional response to that choice.

Something along that lines, I'm going to talk to the client about what I can write that would make them feel more comfortable. I used the example of divorce. They didn't want me to write down the word, divorce. When I said, conflict between you and your husband, that was something that they felt comfortable with.

I've worked with clients that are having hallucinations, but if I use the word, hallucination, it's a trigger for them. When I collaboratively document with them, I talk about it, this is what the client says she is seeing in her brain right now.

It means the same thing, an auditor or another provider or anybody on the treatment team that reads it will certainly know what they mean. But I'm going to do it in a way that the client still feels part of the process, is not going to feel judged and is not going to react in a negative way.

(coughing).

>> Thanks. I don't know if we have, Gwen Davies had a couple of questions, if she wants to ask those if she is able to unmute or anybody else.

>> Hi. Can you hear me?

>> Yes, we can.

>> Right. We don't currently do concurrent documentation, and the rooms that we use don't have computers in them. What do you recommend for, do you recommend tablets? I guess what I'm getting at is, how do you do that in a way that you are still connected to the client? And I know you talked about that and I've been to medical providers and they do it better and worse. What have you found?

>> KATHERINE HIRSCH: I'll tell you that I think a lot of it depends on consistency. So many of us have moved towards electronic health records, and the biggest issue that people run into is connectivity.

If you have staff that are primarily office-based, and using a regular desktop is going to be the most consistent connected type of computer, then that to me is the biggest obstacle to jump over (overlapping speakers).

>> Good, because we have wi-fi in the building.

>> KATHERINE HIRSCH: Okay. I think that a laptop is easier, because sometimes if you want to move the computer, you are able to do that. Certainly if your electronic health record accommodates a tablet and your staff are comfortable with that, then some people will say, that is easier because it's smaller,

doesn't feel so invasive. Whatever, whatever you are using, whether it's a tablet, a computer, it's going to be so much more about how we introduce it to the client, and have them feel a part of it, that in the end, and especially today with technology being what it is, versus when I started collaborative documentation twelve years ago, technology wasn't the same.

I think our clients are so much more accustomed to it, and so I think it would be a great question to ask your staff, because if you want them to really engage in the process, or if you think that there is going to be more success if they have a laptop to use, then I wouldn't say that there is one that is so much better than the other, if you have people going into the community, they definitely say the smaller, the better, just because they have to carry it around, and it's heavy, or they worry about carrying it into certain places.

>> Right. The other question I had was that, we are moving to a electronic medical record that we hope will be able to do a lot of templated writing, so you can click a lot of boxes and it will come up with things. How do you manage that with collaborative documentation? Because that is not, you are not just quoting the client or, do you know what I'm saying?

>> KATHERINE HIRSCH: I do. I'm assuming you mean with treatment plans and dropdown menus, that type of stuff?

>> Mm-hmm but even with a note, you click off on symptoms and it will almost come up with some boilerplate sentences that then you are supposed to edit.

>> I want to jump in really quick to remind people that we are about to go back to the main session promptly at 4:30. We are going to automatically be there, if you want to stay on the Adobe Connect line, I want to give you a chance to answer but if you want to stay in Adobe Connect, stay, but otherwise go to the audio like you did before.

>> KATHERINE HIRSCH: With the dropdown menu, I'll be honest with you, what we have seen a lot of is that those dropdown menus are not client friendly, in the sense that the language often is not in client friendly language. A lot of time staff are seeing that they are ending up having to write something that is more client friendly. I've seen a lot of people deter from some of those dropdown menus because of that.

The clicking of boxes, again, it just kind of is something that if you practice, it becomes more natural and something that people are able to kind of understand, these are, again, it's like doing the mental status. When I talk about, what I talk about with clients, this is me taking a snapshot picture of how you are doing today so that when your symptoms start to change, I get a picture of what you look like depending on how you are doing, how you are feeling, what your facial expressions look

like.

A lot of it is just helping them understand why you are clicking the boxes you are.

The other thing is in the meantime before you go to your electronic health record, a lot of people will start on paper, they find that it's a easier process, so you can go ahead and start on paper, and work on the process of collaborative documentation, and then it might even be easier to transition to your electronic health record.

>> Thank you.

>> KATHERINE HIRSCH: Sure. Any other quick questions? You are welcome to E-mail me, if there are any other questions or anything else that I can do to support you. I believe everybody will get the Power Point, and my E-mail is on the front page.

>> Great, thank you. As a reminder, we are going to go back over, you are seeing the slides now for the ending sessions, and reconnect to audio the way that you were on there. Thank you so much, Katherine Hirsch, we really appreciate it.

>> Thank you. Have a great day.

>> Thanks, bye-bye.

(end of session at 3:30 pm CST.)

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