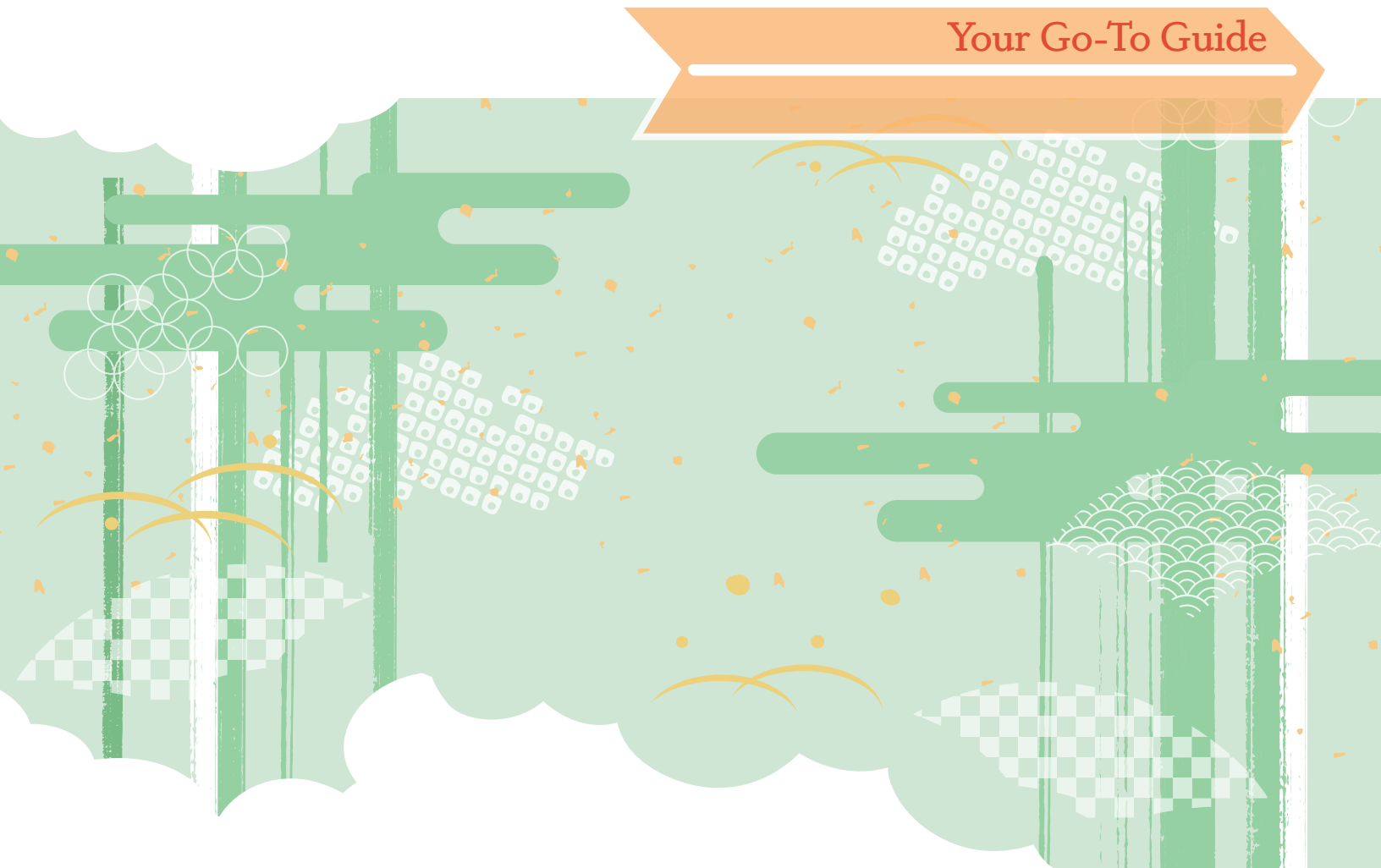


Documentation of Care, Treatment, or Services

IN BEHAVIORAL HEALTH CARE

Your Go-To Guide



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Introduction



Documentation. Documentation. Documentation. As in so many other areas of health care, documentation affects nearly every aspect of care, treatment, or services in behavioral health care. The list of documentation types and uses in this area is long and includes the following:

- Screenings and assessments to support the development of a plan of care, treatment, or services and to guide ongoing interactions with the individuals served
- Plans to guide care, treatment, or services and progress notes to provide a means of communication among clinicians, staff, and individuals served (and their families/guardians and significant others, as appropriate)
- Assessments, plans, and progress notes to justify interventions to third-party payers
- Performance measurement data to help organizations identify potential or actual problems in their processes and to improve the quality of care, treatment, or services
- Specific content required to meet regulatory and accreditation requirements

These aren't new uses for documentation, but they indicate that the need for accurate, timely, and appropriate documentation is as great as it has ever been. Note, however, that The Joint Commission has strategically tried to reduce its focus on documentation during the survey process and instead talks with and listens to organization representatives during the survey and observes how care, treatment, and services are delivered.

Changes to Behavioral Health Care Documentation Standards

Although uses for behavioral health care documentation may not be new, many Joint Commission behavioral health care standards are new or have changed quite a bit in recent years. You should, of course, check the most current version of the standards in your *Comprehensive Accreditation Manual for Behavioral Health Care* (CAMBHC) or its online E-dition® version. Documentation requirements are indicated by a documentation icon next to the requirement. Some of the recent changes to requirements relevant to clinical/case documentation are summarized as follows:

- Organization providing Prevention and Wellness Promotion Services are required to do the following:
 - ✖ Have a written plan for providing those prevention and wellness promotion services relevant to the organization's mission and scope of services.
- Behavioral Health Home (BHH) programs (an optional certification) are required to do the following:
 - ✖ Be accredited under the behavioral health care accreditation standards.
 - ✖ Meet additional standards regarding integration of behavioral and physical health care, treatment, or services, as described in the BHH chapter of the CAMBHC.
- Opioid Treatment programs, as defined in the CAMBHC, are required to do the following:
 - ✖ Document reasons for denying any pregnant applicant.
 - ✖ Receive written authorization to provide interim maintenance treatment from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the state's chief public health officer (if the organization provides such treatment).
 - ✖ Have written criteria for prioritizing the transfer of individuals served from interim maintenance treatment to comprehensive maintenance treatment.
 - ✖ Display names and telephone numbers of whom to contact in case of emergency.
- Organizations providing Housing Support Services, as defined in the CAMBHC, are required to do the following:
 - ✖ Document their regular face-to-face meetings between the individual served and staff.
 - ✖ Perform and document good faith efforts to rapidly rehouse individuals served who have lost their housing due to eviction.
 - ✖ Document the status of individuals reviewed at each meeting of the multidisciplinary care, treatment, or services team (if the organization directly provides both housing support and behavioral or physical health care, treatment, or services).
- Organizations providing care, treatment, or services to individuals with eating disorders are required to do the following:
 - ✖ Perform or make a documented referral for a series of specific physical tests, screenings, and procedures.
 - ✖ Assess outcomes of care, treatment, or services based on data collected at admission.
- Assessing outcomes in any behavioral health setting accredited under the CAMBHC requires the following:
 - ✖ Use of a standardized tool or instrument to monitor the individual's progress in achieving that person's goals.
 - ✖ Gathering, analyzing, and using data generated through standardized monitoring.

This book reflects the most recent set of behavioral health care accreditation and behavioral health care home certification standards available at the time of its writing, as found in the 2018 online E-dition and print version of the *CAMBHC*.

Documentation Themes in This Book

The content of this book not only reflects recent changes to behavioral health care clinical/case documentation standards but also addresses several important emerging and evergreen themes regarding behavioral health care clinical/case documentation. These include the following:

- **Measuring outcomes:** Documentation should support the measurement of an individual's outcomes as that person responds to care, treatment, or services—outcomes that are applicable to multiple purposes, including adapting the plan for care, treatment, or services as necessary.
- **Adjusting plans to support the individual's progress:** Documentation should inform and support changes to the individual's plan for care, treatment, or services as the individual progresses (or regresses).
- **Integration of physical and behavioral health care:** Documentation should integrate both physical and behavioral/emotional assessment of the individual served, to identify and address areas where those aspects of health affect each other.
- **Care, treatment, or services centered around the individual served:** Documentation should incorporate the individual's own words as much as possible to encourage that person's investment in progress toward recovery or as part of continuing care, treatment, or services.
- **Quality, effective documentation:** Documentation should be easy to read and understand, thorough, accurate, and timely.
- **Recovery/resilience, with a focus on the individual's needs, strengths, preferences, and goals:** Documentation should support the recovery or resilience of individuals served, always centered around how the individual's needs, strengths, and preferences can be used to meet the individual's goals.

Audience for This Book

This book is written for anyone in a behavioral health care organization who works with documentation of the care, treatment, or services provided to individuals served. The focus is on helping accredited organizations maintain compliance and create and use effective documentation. However, non-accredited organizations may also benefit from this book, as they can use it to learn about the Joint Commission's expectations regarding documentation.



Structure of This Book

Documentation of Care, Treatment, or Services in Behavioral Health Care: Your Go-To Guide is a clear, concise, accurate reference that breaks down complex concepts into easy-to-digest pieces. You can read them in order, or you can jump to the topic you need. The book includes three chapters:



- **Chapter 1 Overview of Behavioral Health Care Documentation:** This chapter introduces the basic concepts of documentation in behavioral health care. It explains the importance of documentation and describes the various types of documentation that occur during care, treatment, or services. Discussions of the cyclical process of care, treatment, or services and the core steps of that cyclical process are central topics in the chapter. The chapter also includes information about other organizational systems supported by documentation activities, and it concludes with a discussion of the factors that affect the development of effective, high-quality documentation.
- **Chapter 2 Documentation of Screening and Assessment of Care, Treatment, or Services:** This chapter discusses several important types of screenings and assessments used in behavioral health care, including the initial, physical, and behavioral/emotional screenings and assessments. Information on other assessment data—such as strength, cultural, generational, and spiritual assessments—is also provided. The chapter concludes with discussions of analyzing data collected from screenings and assessments and common challenges you may encounter when performing these activities.
- **Chapter 3 Documentation of Planning, Delivery, and Continuity of Care, Treatment, or Services:** This chapter focuses on how information gathered through screenings and assessments is used in the planning, delivery, and continuity of care, treatment, or services. It emphasizes the participation of the individual served throughout the process: from creating the individualized plan for care, treatment, or services, to responding to changes, to transitioning to another level of care, treatment, or services through transfer or discharge. The chapter describes some related challenges and how to address them effectively.

An appendix and a glossary of terms are included in this book as well. Each contains important materials you need to get the most out of this book. They are as follows:

- **Appendix: Tools to Try:** The Appendix provides a number of documentation forms, checklists, and other tools. One set of tools has been standardized in form and content to demonstrate how documentation tools work together; these tools are designed to be easy to use, yet comprehensive in application to the process of care, treatment, or services. Several of these documentation forms are shown completed for a fictional individual served. All are included in blank form for download: Users of the e-book download from links, while users of the print edition go to a website address* provided to download the tools. Content in these forms represent appropriate content for hard-copy (paper) forms or electronic health record (EHR) forms of the type represented. Note that The Joint Commission does not endorse or require any of these specific, particular example forms.
- **Glossary:** The Glossary defines all the key terms listed in each chapter. If you're using the electronic version of this book, each term is hyperlinked at the opening of each chapter and at an important use in the chapter; clicking on the hyperlinked terms in the text will take you to the Glossary.

A New Approach: Information for Application

Understanding and applying the standards regarding clinical/case documentation in behavioral health care settings can be challenging. After all, these standards deal with the myriad issues of providing quality care, treatment, or services of individuals served in numerous and various settings, programs, and services. To help you understand the documentation requirements in behavioral health care, Joint Commission Resources has published four editions of a particular book on this topic: *A Practical Guide to Documentation in Behavioral Health Care*. The most recent edition was published in 2012.

Since 2012, behavioral health care standards have changed significantly—and so has the way information is shared. We now get much of our published information in accessible and succinct chunks—often framed in a mobile device and/or online in brief text blocks, bulleted lists, and informational graphics (infographics). Also, the information itself is more practical than theoretical; it's often intended to be immediately applicable: Read it and use it. This reflects an understanding that consumers don't have much time to spare to get the information and tools they need *right now*.

In response to this development in learning and publishing, Joint Commission Resources has created a new approach for some of its books—one that makes even complex content easier to read and use. *Documentation of Care, Treatment, or Services in Behavioral Health Care: Your Go-To Guide* uses this new approach to offer new information as well as updated content from the most recent edition of *A Practical Guide to Documentation in Behavioral Health Care*.

The content is presented in a way that takes you swiftly from information to application. Each chapter starts with a brief introduction and then presents information through a series of short, recurring features. These features are written to stand alone, although they do follow a logical order within the chapter.

To help you quickly find what you're looking for, the features are grouped into sections related to a set of specific standards. The standards are mostly from the "Care, Treatment, and Services" and "Record of Care, Treatment, and Services" chapters of the online E-dition and print version of the *CAMBHC*, though relevant standards from other chapters are included as well. Each chapter contains several sections that include one or more of each of the features described below.

- **Terms & Topics:** This feature appears right after the introduction to each chapter. It contains a list of important terms (defined in the Glossary) that you'll encounter in the chapter. It also lists the topics covered in the chapter sections and the relevant standards for each. Each topic has its own section in the chapter, introduced by a "Section Sets" feature (described next). Terms and relevant standards are indicated in underlined blue text so you know to look for them in the Glossary. As already noted, for those using the electronic version of this book, these terms are hyperlinked to the Glossary.
- **Section Sets:** This feature is used to open a section on one of the topics listed in the Terms & Topics feature. It provides a brief description of the main issues covered in the relevant standards for the topic and includes the text of relevant standards as well.

Terms
& topics

SECTION SETS

CONCISE CONCEPTS

Examples to *Examine*

EXCERPTS that EXPLAIN



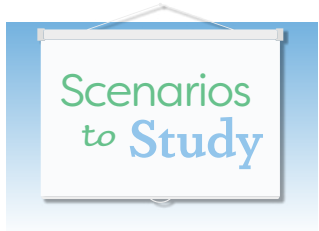
FOCUS ON FAQs

INSTRUCTIVE INFOGRAPHICS

PARTICULAR POINTS



SUCCESSFUL STRATEGIES



- **Concise Concepts:** This feature briefly summarizes an idea that is perhaps self-explanatory but important enough to emphasize. The idea is phrased in one or two sentences, which are broken down to highlight and clarify the concept in terms of who, what, when, where, why, and how.
- **Examples to Examine:** This feature offers example documentation entries that demonstrate appropriate language style and content for documentation under discussion in the chapter section.
- **Excerpts That Explain:** This feature shares relevant excerpts from sources such as the introductions and rationales for Joint Commission standards from the online E-dition and print version of the CAMBHC.
- **Focus on FAQs:** This feature highlights frequently asked questions from The Joint Commission's website. These are real questions asked by organizations and answered by members of the Standards Interpretation Group (SIG).
- **Instructive Infographics:** This feature incorporates a graphic element, an infographic, or an illustration that makes important information clear. This feature is used to depict relationships, decision-making criteria, and processes.
- **Particular Points:** This feature uses bulleted lists to highlight important information. These points are also used to explain fine points of distinction or interpretation of behavioral health care standards and related concepts.
- **Tools to Try:** This feature includes checklists, forms, and other tools you can adapt for use in your organization. The feature includes a brief description of a tool and how it's used; each tool can be found in the Appendix. More than two dozen downloadable, writable tools are provided in this book. Several documents are completed with fictional information to show you how a particular tool can be filled out and used effectively. Tools completed in this feature are available to download as blank tools. As noted, users of the e-book download from links, while users of the print edition go to a website address* provided to download the tools.
- **Successful Strategies:** This feature, which appears toward the end of each chapter, contains information that expands beyond the topics covered in the chapter, with application in special programs/settings and strategies or tips that address related issues.
- **Scenarios to Study:** This feature, which closes out each chapter, focuses on issues related to the standards and key concepts covered in the chapter. Each scenario describes a process or an approach to address the issues. It also includes a flowchart or diagram that illustrates application of the approach.

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- Summer Sky, Stephenville, Texas

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Overview of Behavioral Health Care Documentation

Clinical documentation in behavioral health care tells a story. That story recounts the entire process of care, treatment, or services for an individual served, including any transfer or discharge. The story must be founded on timely, complete, accurate data continuously collected and analyzed. This enables appropriate assessment of needs and an individualized plan for care, treatment, or services that reflects the individual's progress.

Yet, although the plan is individualized, clinical documentation involves recording information about the same core steps in every story. And those steps involve elements in a common cyclical process in the care, treatment, and services system. That system is supported by functions such as performance improvement, billing and reimbursement, and resource allocation that also require documentation. This chapter introduces you to these basic concepts of documentation in behavioral health care. Later chapters provide more detail about each core step.

A variety of graphics and tools will be presented in this chapter to help you understand the important ideas and relevant standards. The chapter will end with a set of strategies for a particular area and a scenario that shows you how the chapter concepts and standards are applied in a real-world situation.

Terms & topics

glossary terms

assessment; authenticate; behavioral health care; behavioral/emotional functioning; clinical/case record; continuing care, treatment, or services; continuity of care, treatment, or services; data; discharge; discharge planning; documentation; goals; history and physical; individual served; interventionist; interventions; mock tracer; objectives; outcome; partial hospitalization program; performance improvement; plan for care, treatment, or services; progress notes; reassessment; referral; screening; services; transfer; trauma

chapter topics

The Basics of Behavioral Health Care Documentation:

RC.01.01.01, RC.01.02.01, RC.01.03.01, RC.01.04.01, RC.02.01.01, RC.02.04.01

The Cyclical Process of Care, Treatment, or Services:

RC.01.01.01, RC.01.02.01, RC.01.03.01, RC.01.04.01, RC.01.05.01, RC.02.01.01, RC.02.03.07, RC.02.04.01

Core Steps of Care, Treatment, or Services: CTS.02.01.03, CTS.02.01.05, CTS.02.01.06, CTS.02.02.05, CTS.02.03.05, CTS.02.03.07, CTS.02.03.11, CTS.02.04.01, CTS.06.01.11, CTS.06.01.15

Support for the Care, Treatment, or Services System:

LD.04.01.11, PI.01.01.01, PI.02.01.01, PI.03.01.01, RC.01.01.01, RC.01.03.01, RC.01.05.01

Effective, Quality Documentation: RC.01.01.01, RC.01.05.01, IM.01.01.01, IM.01.01.03, IM.02.01.01, IM.02.01.03, IM.02.02.01, IM.02.02.03, CTS.03.01.09, LD.04.01.07



SECTION SETS

The Basics of Behavioral Health Care Documentation

The information in this section helps you become familiar with the basics of behavioral health care documentation, particularly in relation to the clinical/case record for the individual served. Issues addressed include ensuring the completeness, accuracy, authentication, and timeliness of entries, including verbal orders, as well as ensuring that the record documents care, treatment, or services provided—including discharge information, if applicable.

The following are relevant standards for this section:

- ⦿ **RC.01.01.01:** The organization maintains complete and accurate clinical/case records.
- ⦿ **RC.01.02.01:** Entries in the clinical/case record are authenticated.
- ⦿ **RC.01.03.01:** Documentation in the clinical/care record is entered in a timely manner.
- ⦿ **RC.01.04.01:** The organization audits its clinical/case records.
- ⦿ **RC.02.01.01:** The clinical/case record contains information that reflects the care, treatment, or services provided to the individual served.
- ⦿ **RC.02.04.01:** The organization documents the discharge information of the individual served.

CONCISE CONCEPTS

Documentation of Care, Treatment, or Services

*Documentation affects
nearly every aspect of
care, treatment, or services
in behavioral health care organizations.*



INSTRUCTIVE INFOGRAPHICS

The Five W's of Behavioral Health Care Documentation

To understand the basics of any concept, you often have to begin with some simple questions, like the “five W’s”: what, who, when, where, and why. The following chart answers these questions in regard to behavioral health care documentation. Answers may vary somewhat, however, depending on the specific program or setting.

WHAT is it?	• Generally refers to the <i>clinical/case records</i> of the care, treatment, or services and other clinical/case forms and notes • Describes care, treatment, or services provided • Contains demographic information
WHO does it?	• Staff, behavioral health care professionals, or the multidisciplinary care, treatment, or services team (for example, caregiver staff, foster care workers, case managers, <i>interventionists</i>, drug and alcohol counselors, social workers, and clinicians such as physicians, clinical psychologists, clinical social workers, or clinical professional counselors) • Competent external providers when specialty testing or examinations are required • Individuals served when completing forms, questionnaires, and so on
WHEN is it done?	• Beginning and end of an experience of care, treatment, or services • Throughout the care, treatment, or services experience: – On a regular basis – As needed – As quickly as possible to avoid delays in care, treatment, or services
WHERE is it done?	• In behavioral health care organizations: – By phone – In person • In settings such as intensive outpatient/<i>partial hospitalization programs</i>, therapeutic schools, group homes, prisons, and other locations where behavioral health care is provided • In the community (for example, assertive community treatment and community support services) • In the individual’s home, when appropriate (for example, foster care and in-home services)
WHY is it done?	• Supports the care, treatment, or services process in the following ways: – Forms the basis for decisions about whether to provide care, treatment, or services – If providing care, treatment, or services, determines which are needed and at what levels – Justifies the need for care, treatment, or services – Confirms that care, treatment, or services were carried out according to an approved plan – Captures necessary data to measure the general process and the care, treatment, or services <i>outcomes</i> – Promotes <i>continuity of care, treatment, or services</i> • Complies with laws and regulations, including those related to reimbursements

INSTRUCTIVE INFOGRAPHICS

Types of Behavioral Health Care Documentation

The *what* list of documentation for behavioral health care clinical/case records can be quite extensive: You need to document *all* clinical/case information that reflects care, treatment, or services provided. The chart below shows the various types of documentation you're required to document, per Joint Commission standards. Other types of documentation for support processes are touched on later in this chapter.

Demographic Information	
- Name, address, date of birth, and sex of the individual served - Name and contact information for the individual's family/guardian and/or significant others (as appropriate) and any legally authorized representative - Preferred language and any special communication needs	
Clinical/Case Information	
Always Include	Include If Applicable
- Reason(s) for care, treatment, or services - Findings of required screenings, assessments, or reassessments - Initial diagnoses, diagnostic impressions, or conditions <u>Plan for care, treatment, or services</u> and revisions to the plan - Response to care, treatment, or services	- Findings of nonrequired screenings, assessments, or <u>reassessments</u> - Orders for diagnostic and therapeutic tests and procedures, and their results - Conclusions or impressions based on physical health screening and/or health and physical examination - Diagnoses, diagnostic impressions, or conditions established during the course of care, treatment, or services - Consultation reports - Observations relevant to care, treatment, or services - Emergency care, treatment, or services provided before arrival or during care, treatment, or services <u>Progress notes</u> - Medications ordered or prescribed - Medications administered (including strength, dose, and route) - For intravenous therapy, access site for medication, administration devices used, and rate of administration - Adverse drug reactions
Additional Information (if applicable and as needed)	
- Advance psychiatric directives - Informed consent - Documentation of protective services - Documentation of consent for the following: - Admission (if applicable) - Care, treatment, or services - Evaluation <u>Continuing care, treatment, or services</u> - Research (if applicable)	

Additional Information (if applicable and as needed) *continued*

- Records of communication with the individual served
- Documentation of involvement in care, treatment, or services by the individual served and family/guardian and/or significant others (as appropriate)
- Information on unusual occurrences, such as the following:
 - Complications
 - Accidents or injuries to the individual served
 - Procedures that place the individual served at risk or cause pain
 - Other illnesses or conditions that affect care, treatment, or services
 - Death of the individual served
 - Indications for and episodes of special procedures, such as physical holding of child/youth, restraint, and seclusion

Discharge Information (if applicable)

- Discharge summary that includes the reason for acceptance for care, treatment, or services
 - Care, treatment, or services provided
 - Condition at discharge of the individual served
 - Information provided to the individual served or the family, such as the following:
 - ▶ Written discharge instructions
 - ▶ Medication regimen
 - ▶ Follow-up care, treatment, or services

EXCERPTS that EXPLAIN**A Complete Clinical/Case Record**

The “Record of Care, Treatment, and Services” (RC) chapter contains information about the components of a complete clinical/case record. A highly detailed document when seen in its entirety, the clinical/case record comprises all data and information gathered about an individual served from the moment he or she enters the organization to the moment of discharge or transfer [or throughout continuing care, treatment, or services]. As such, the clinical/case record functions not only as a historical record of an individual’s episode(s) of care but also as a method of communication among staff that can facilitate the continuity of care and aid in making decisions about care, treatment, or services.

—Overview in the “Record of Care, Treatment, and Services” chapter,
Comprehensive Accreditation Manual for Behavioral Health Care and its online E-dition version

PARTICULAR POINTS

Dated and Authorized Orders

- The *who* and *when* of clinical/case record documentation need special attention when individuals are dependent on authorized caregivers for getting timely care, treatment, or services. Both written and verbal orders need to be documented and authenticated in a timely manner, as defined in written policy and according to laws and regulations. You're required to run audits on your organization's clinical/case records to make sure that all orders are properly dated and authorized in a timely manner. In addition, your organization must define how frequently these audits happen. The diagrams below detail what authentication means and how verbal orders must be documented.



Only authorized staff make entries for written orders.

The author of each written order is identified.



Emily Fong



Larry Lancaster

Written order entries are countersigned when necessary.

Verbal orders must be documented with the date and name of staff for the following:



Almira Jacard, MD
3/16/18

When the order was given



Emily Fong
3/16/18

When the order was received



Emily Fong
3/16/18

When the order was recorded



Emily Fong
3/16/18

When the order was implemented