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A comprehensive guide to creating mental health treatment plans:

Everything inpatient behavioral health providers need to know

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What is a treatment plan, and why does it matter?

In behavioral health, a mental health treatment plan refers to the written document that outlines the proposed goals, plans, and methods that the interdisciplinary team (IDT) will use to achieve the optimal outcome for the client. This comprehensive plan is personalized and designed to meet the unique needs of the client.

Treatment plans are important because they give the IDT a full picture of the different types of therapy the client is engaging in and provide an assessment of the client's reaction to that treatment. More importantly, these plans outline a clear direction on how to improve behaviors and other problems impacting the client's life. Notes allow the IDT to track a client's progress, stay organized, and adjust the plan as needed.

In accordance with 42 Code of Federal Regulation (CFR) 412.27(c)(3) and 42 CFR 492.61(c), each inpatient psychiatric patient **must** have an individual comprehensive treatment plan. This plan must be based on an inventory of the patient's strengths and disabilities.

It is important to include the client in the treatment planning process. If the client does not accept that they need treatment, it will be hard to achieve the goals listed on the treatment plan. Collaboration between the IDT and client leads to highly personalized treatment plans. By including the client in the treatment planning process, the IDT can accurately capture and articulate the goals of the client.

Important Note:

To receive payment from the Centers for Medicare & Medicaid Services (CMS), inpatient psychiatric facilities are required to have adequate numbers of qualified professional and supportive staff that can evaluate inpatients and **formulate written, individualized, comprehensive treatment plans.**

The elements of a mental health treatment plan

Written treatment plans must include specific elements. These elements include:

- A substantiated diagnosis
- Short-term and long-range goals
- The specific treatment modalities utilized
- The responsibilities of each team member of the treatment plan
- Adequate documentation to justify the diagnosis and treatment and rehabilitation activities carried out

A substantiated diagnosis

This diagnosis should be used as a reference to build out the client's treatment plan. It is the starting point for creating goals and interventions. The diagnosis in the treatment plan should be the one for which the client is actively receiving treatment. This is often referred to as the problem statement. The problem statement should not have multiple diagnoses lumped together. Instead, separate these into separate problems.

Short-term and long-range goals

All goals should be realistic and achievable. Consider using SMART (Specific, Measurable, Achievable, Relevant, Time-Bound) goals in your treatment plan. This type of goal planning will help personalize your treatment plan. The long-range goal is what the client should achieve by discharge. Short-term goals are the steps that the client must reach to achieve the long-term goal.

The specific treatment modalities utilized

This includes the different therapies and activities the IDT are utilizing to ensure the client is reaching the established SMART goals. This part of the treatment plan is often referred to as interventions.

The responsibilities of each team member

In this section, cite which member of the IDT is responsible for carrying out the intervention. Provide specific details about the timeline (i.e., twice weekly, weekly, etc.) and how the intervention relates to the problem statement.

Adequate documentation

Update the treatment plan as progress occurs. Documentation should show the specific steps your staff takes to execute the prescribed treatment plan.

The impact treatment plans have on surveys

Both CMS and The Joint Commission (TJC) are two governing bodies responsible for ensuring inpatient behavioral health hospitals are in compliance with stated regulations. To ensure compliance, CMS and TJC survey organizations to ensure conditions of participation (CoPs) are met. Failure to comply with these regulations prevents the organization from receiving federal funding.

Client treatment plans are examined during surveys. CMS and TJC commonly cite treatment plans as an area of improvement. To ensure compliance behavioral health providers must understand what surveyors are looking for.

Preventing denials

CMS and TJC commonly flag treatment planning issues during surveys. If errors are found during a survey, TJC or CMS can issue an Immediate Jeopardy status. This means the location must fix the cited issues within a specified timeframe or risk losing federal funding.

Below are some commonly cited errors found in treatment plans:

- In the **substantiated diagnosis,** surveyors often state that the problem statement is not written in behavioral terms or it is not individualized to the client. To ensure staff are writing individualized problem statements that describe the patient's behavior, it's helpful to include the phrase "as evidenced by." This phrase encourages the staff to explain how the diagnosis relates to the client.
- Surveyors often find that staff do not use behavioral health terms in **short-term and long-range goals.** In addition, surveyors note that goals are not measurable, nor are they personalized to the individual. Remember, objectives should not describe what the staff will do, and they should not be something that could apply to all clients.
- To ensure compliance on surveys, the **treatment modalities** listed on the treatment plan must be specific and should not include routine or general care. The intervention listed should include the focus or purpose. It should also include **the responsibility of each team member.**
- Staff should update the treatment plan often to demonstrate the progress the client is making towards the long-term goal. This helps **justify the services** provided as they relate to the diagnosis on the problem statement.
- Finally, all treatment plans **must have a signature** from the people responsible for the care of the client. Without a signature and a date, the treatment plan is considered incomplete.

Consider creating a checklist to ensure your team is creating compliant treatment plans.

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How technology drives compliance

- **Sharing client data**
  Ensures the problem statement is personalized and can help create a history that can justify the services listed to support the diagnosis.
- **Supporting the documentation of interventions**
  Ensures your team is providing adequate documentation, and allows you to adjust the treatment plan.
- **Client participation**
  Ensures the short-term and long-range goals are personalized, and helps justify the services provided.

Using technology to drive compliant treatment plans

Today, the majority of inpatient behavioral health providers document on paper. This time-consuming process results in less collaboration, billing issues, and compliance errors. Behavioral health technology, like a purpose-built electronic health record (EHR), assists providers with complete and accurate documentation during the treatment planning process. This technology stores critical client information and pulls that information forward throughout the documentation process.

Here are a few ways technology can help drive compliant treatment plans in a behavioral health hospital:

Sharing client data

Each person is unique. To build an individualized treatment plan, your staff must understand the psychosocial, treatment, and diagnosis history of the client. Technology can help streamline the sharing of data by pulling significant data from the client's past into the current admission. This data should then flow into initial assessments and notes, triggering documentation logic that prompts staff to ask the right questions. This not only ensures a personalized experience for your clients, but also eases the documentation burden on your staff.

Supporting the documentation of interventions

Once the initial problem statement is determined, your staff must build out a treatment plan that includes achievable goals and the interventions that will be used to meet those goals. To ensure compliance, your staff must provide adequate documentation to support the problem statement. Technology can track the completion of any tagged interventions which helps support the execution of the treatment plan. Depending on how intuitive your technology is, alerts can also allow for course correction by letting your staff know if a goal or objective is no longer attainable.

Ensuring progress notes enter the treatment plan

Like documenting interventions, your staff must ensure that all identified issues make it from the progress note to the treatment plan. When working with a client, they may share subjective elements about any new symptoms. From this, your staff can determine an objective diagnosis. Information about this diagnosis should be carried forward from the note to the treatment plan. With technology, your team can set up notifications to ensure your staff is alerted if any pertinent information is not carried forward.

Client participation

Patient self-reporting functionality is a major benefit of technology. Allowing a patient to document an outcome or personal experience with the intervention adds another layer of personalization to the treatment plan.

About the author

Carrie O'Connell, RN, is the senior director of clinical services at WellSky. Carrie's wealth of knowledge and expertise in healthcare informatics spans more than 20 years. Her focus includes the strategic design and direction of clinical solutions, regulatory guidance, educational services, client training, and implementation success. Carrie serves as a board member of the National Association for the Support of Long-Term Care (NASL), and was asked to participate in CMS's LTACH Function Quality Measure Development Technical Expert Panel (TEP). Carrie is a frequent presenter at national conventions, including Behavioral Health Business INVEST.

WellSky Specialty Care for Behavioral Health is an all-in-one healthcare information technology platform that spans electronic health records (EHR), revenue cycle management, financial management, and business intelligence. The WellSky Specialty Care platform helps providers deliver better quality and safety of care while increasing efficiencies and financial performance. Our easy-to-use solution promotes a culture of safety with behavioral health specific features, including a built-in accountability record and alerts that power safe and effective care delivery.

Ensure treatment plan compliance with WellSky. Connect with a WellSky expert to learn how our solution utilizes alerts and notifications to streamline the creation of accurate, compliant treatment plans.

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