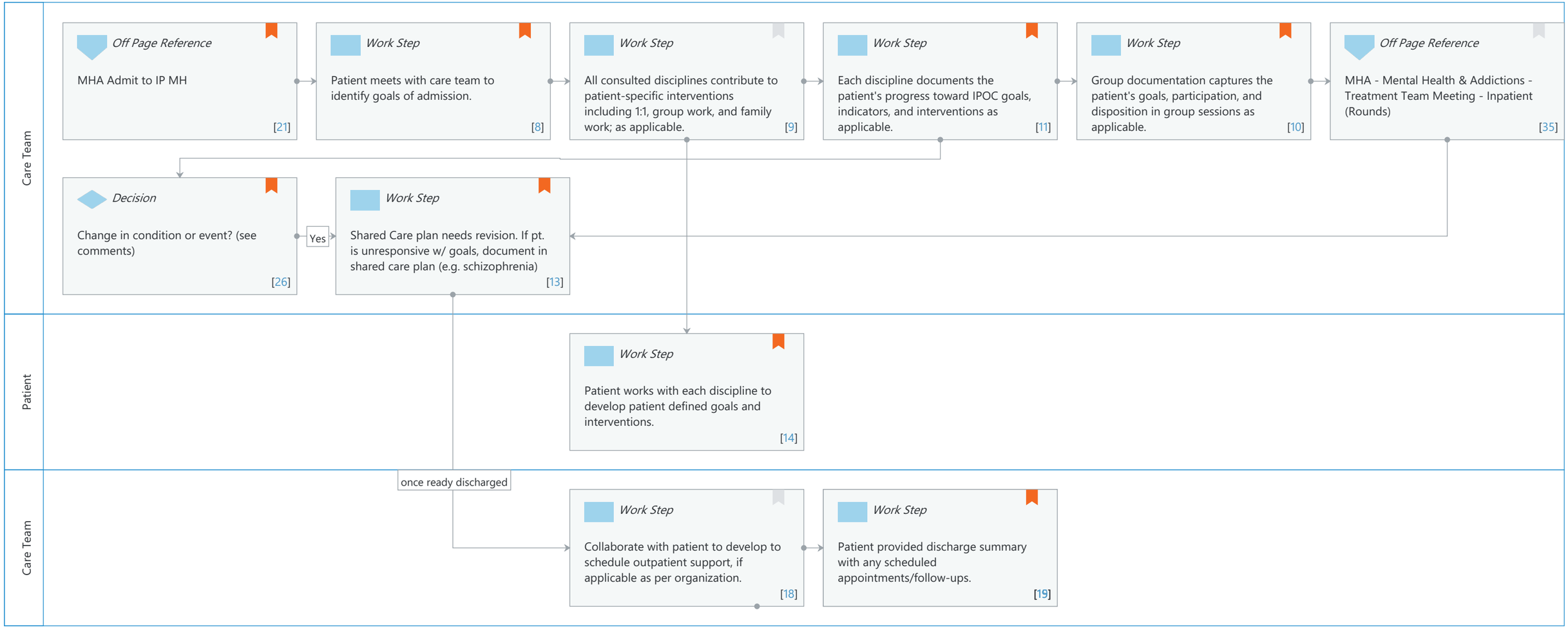
Niagara Health System

Oct 11, 2024

Future State: MHA - Mental Health & Addictions - Treatment Planning - Inpatient

Cerner Workflow ID: 9315 (v. 13.0) Client Workflow ID: 371

Last updated by Julia Becevel, Jan 31, 2024 3:49pm (UTC -4 hours)



Future State: MHA - Mental Health & Addictions - Treatment Planning - Inpatient

Cerner Workflow ID: 9315 (v. 13.0) Client Workflow ID: 371 Last updated by Julia Becevel, Jan 31, 2024 3:49pm (UTC -4 hours)

Workflow Details:

Workflow Name:	MHA - Mental Health & Addictions - Treatment Planning - Inpatient
Workflow State:	Future State
Workstream:	Ongoing Assessment and Treatment
Venue:	Hospital Based Behavioral Health
Client Owner:	
Cerner Owner:	
Standard:	Yes
Related Workflow(s):	
Tags:	

Workflow Summary:

Service Line:	
Related Solution(s):	Millennium Behavioral Health
Project Name:	Niagara Health System:OPT-0297674:NIAG_CD Niagara HIS RFP
TestBuilder Script(s):	
Cerner Workflow ID:	9315 (v. 13.0)
Client Workflow ID:	371
Workflow Notes:	
Introduced By:	WS 3
Validated By:	WS 4

Swim Lane:

Role(s):	Care Team
Department(s):	
Security Position(s):	BH - Nurse BH - Tech BH - Student Nurse BH - Therapy/Psychology Student Physician - Psychiatry BH - Therapist BH - Nurse Supervisor BH - Recreational Therapist

Off Page Reference [21]

Workflow Link:	MHA Admit to IP MH
Comments:	Patient is admitted. Providers and other disciplines will document on the same Patient Strength DTAs. Probe §482.61(c)(1) Has the information gained from assessing/evaluating the patient been utilized to create an individualized treatment plan? B119 §482.61(c)

(1) The plan must be based on an inventory of the patient's strengths and disabilities. A disability is any psychiatric, biopsychosocial problem requiring treatment/intervention. The term disability and problem are used interchangeably. The treatment plan is derived from the information contained in the psychiatric evaluation and in the assessments/diagnostic data collected by the total treatment team. Based on the assessment summaries formulated by team members of various disciplines, the treatment team identifies which patient disabilities will be treated during hospitalization. Patient strengths that can be utilized in treatment must be identified. (See also §482.61(b)(7).) At 482.61(b)(6) CMS provides the following guidance regarding what is considered a strength: Guidance §482.61(b)(7): Although the term strength is often used interchangeably with assets, only the assets that describe personal factors on which to base the treatment plan or which are useful in therapy represent personal strengths. Strengths are personal attributes i.e., knowledge, interests, skills, aptitudes, personal experiences, education, talents and employment status, which may be useful in developing a meaningful treatment plan. For purposes of the regulation, words such as "youth," " pretty," "Social Security income," and "has a car" do not represent assets. (See also §482.61(c)(

Work Step [8]

Description: Patient meets with care team to identify goals of admission.

Comments: §482.61(c) Standard: Treatment Plan Each patient must have an individual comprehensive treatment plan The patient and treatment team collaboratively develop the patient's treatment plan. The treatment plan is the outline of what the hospital has committed itself to do for the patient, based on an assessment of the patient' s needs. Probes §482.61(c)(1) Is the treatment plan individualized, i.e., patient-specific, or is there a predictable sameness from plan to plan? The written plan must include— A substantiated diagnosis; The substantiated diagnosis serves as the basis for treatment interventions. A substantiated diagnosis is the diagnosis identified by the treatment team to be the primary focus upon which treatment planning will be based. Probes §482.61(c)(1)(i) What specific problems will be treated during the patient's hospitalization? Does the treatment plan identify and precisely describe problem behaviors rather than generalized statements i.e.,

"paranoid," "aggressive," "depressed?" or generic terminology i.e., "alteration in thought process," "ineffective coping," "alteration in mood?" Are physical problems identified and included in the treatment plan if they require treatment, or interfere with treatment, during the patient's hospitalization?Probes §482.61(c)(1)(ii) How do treatment plan goals relate to the problems being treated? Do goals indicate the outcomes to be achieved by the patient? Are the goals written in a way that allow changes in the patient's behavior to be measured? If not apparent, what criteria do staff use to measure success? How relevant are the treatment plan goals to the patient's condition? B122 §482.61(c)(1)(iii) The written plan must include— The specific treatment modalities utilized; Having identified the problems requiring treatment, and defining outcome goals to be achieved, appropriate treatment approaches must be identified. Modalities include all of the active treatment measures provided to the patient. It describes the treatment that will be provided to the patient. It describes the treatment that will be provided by various staff. A daily schedule of unit activities does not, in itself, constitute planned modalities of treatment. Simply "naming" modalities (i.e., individual therapy, group therapy, occupational therapy, medication education) is not acceptable. The focus of the treatment must be included. Simply "stating" modality approaches (i.e., "set limits," "encourage socialization," "discharge planning as needed") is not acceptable. Modality approaches must be specifically described in order to assure consistency of approach. It must be clear to you that the active treatment received by the patient is internally consistent and not simply a series of disconnected specific modalities delivered within certain scheduled intervals. Probes § 482.61(c)(1)(iii) Are observed treatment methods, approaches and interventions from all disciplines included in the plan? Do the disciplines present at observed treatment planning meetings represent all of the patient's needs? Is the patient included in the decision-making, whenever possible? How does the patient get to know his/her treatment regime? How does the treatment team encourage the patient to accept responsibility for engaging in the treatment regime, rather than accepting it passively?

Work Step [9]

Description: All consulted disciplines contribute to patient-specific interventions including 1:1, group work, and family work; as applicable.

Work Step [11]

Description: Each discipline documents the patient's progress toward IPOC goals, indicators, and interventions as applicable.

Comments: Treatment note = therapeutic doc
Progress note = discipline specific progress note_type

Active treatment is an essential requirement for inpatient psychiatric care. Clarification of the types of notes found in the medical record. Treatment notes are recordings in the medical record that indicate provision of, and a patient's response to, a specific modality. This modality may be drug therapy, individual, family, marital, or group therapy, art therapy, recreational therapy, and any specialized therapy ordered by the physician or anyone credentialed by the facility, in accordance with the State law, to write orders in the medical record. A combined treatment and progress note may be written. Progress notes are recordings in the medical record that are written by persons directly responsible for the care and active treatment of the patient. Progress notes give a chronological picture of how the patient is progressing toward the accomplishment of the individual goals in the treatment plan. These are frequently shift notes, weekly notes, or monthly notes. §482.61(d) Standard: Recording Progress - Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the patient, nurse, social worker, and when appropriate, others significantly involved in active treatment modalities. The recording of progress is evidence of individual patient performance. Specifically, the progress notes recorded by the professional staff, or others responsible for the patient's treatment, must give a chronological picture of the patient's progress or lack of progress towards attaining short and long-range goals outlined in the individual treatment plan. Progress notes should relate to the goals of the treatment plan. Notes should be dated and signed (signature and title or discipline). Probes §482.61(d) Do the progress notes relate to the goals of the treatment plan? Do they include precise statements of progress? Do the notes give a clear picture of the

patient's progress or lack thereof, during the course of hospitalization? B131 §482.61(d) Probes §482.61(d)Do the progress notes contain documentation substantiating changes/revisions in the treatment plan and subsequent assessment of the patient's responses and progress B132 §482.61(d)Probes §482.61(d) Are the progress notes related to the goals of the treatment plan?

Work Step [10]

Description: Group documentation captures the patient's goals, participation, and disposition in group sessions as applicable.

Comments: If additional problems are identified, appropriate LTG/objective, STG, and interventions as needed.There must be evidence of periodic review of the patient's response and progress toward meeting planned goals. If the patient has made progress toward meeting goals, or if there is a lack of progress, the review must justify: (1) continuing with the current goals and approaches; or (2) revising the treatment plan to increase the possibility of a successful treatment outcome. B124 §482.61(c)(1)(v)When the progress and treatment notes are reviewed, the content of the notes must relate to the treatment plan. The notes must indicate what the hospital staff is doing to carry out the treatment plan and the patient's response to the interventions. Probes §482.61(c)(1)(v) Are the treatment notes relative to the identified problems? Are the treatment notes indicative of the patient's response to treatment? Do the progress notes relate to specific patient problems or progress? B125 §482.61(c)(2) Active treatment is an essential requirement for inpatient psychiatric care. Clarification of the types of notes found in the medical record. Treatment notes are recordings in the medical record that indicate provision of, and a patient's response to, a specific modality. This modality may be drug therapy, individual, family, marital, or group therapy, art therapy, recreational therapy, and any specialized therapy ordered by the physician or anyone credentialed by the facility, in accordance with the State law, to write orders in the medical record. A combined treatment and progress note may be written. Progress notes are recordings in the medical record that are written by persons directly responsible for the care and active treatment of the patient. Progress notes give a chronological picture of how the patient is progressing toward the accomplishment of the individual goals in the treatment plan. These are frequently

shift notes, weekly notes, or monthly notes

Off Page Reference [35]

Workflow Link: MHA - Mental Health & Addictions - Treatment Team Meeting - Inpatient (Rounds)

Decision [26]

Description: Change in condition or event? (see comments)

Comments: If these events occur, document in iView, flag so the incident appears in the flagged events tile, add precaution order if necessary, and update plan to add goals/interventions as necessary.

Physical Aggression
Verbal Aggression/Threat
Seclusion Episode
Restraint Episode
Self-Harm Behavior
Suicidal Behavior
Organize peers in destructive/aggressive behavior

Jeopardizing safety of milieu
1:1 Engagement
2:1 Engagement
Continuous Treatment
Intervention Plan Event
Accident
Sexual Behavior
Attempting Unauthorized
Leave
Completed Unauthorized Leave
Medical Concern
Patient Initiated
Review
Community Support Initiated Review
Clinical Case Conference
Individualized Behavioral Plan

Work Step [13]

Description: Shared Care plan needs revision. If pt. is unresponsive w/ goals, document in shared care plan (e.g. schizophrenia)

Comments: Sites may want to capture a plan change note - use smart template to

capture snapshot. If a new note type is required, add to the treatment team folder.

Swim Lane:

Role(s): Patient
Department(s):
Security Position(s):

Work Step [14]

Description: Patient works with each discipline to develop patient defined goals and interventions.

Comments: Probes §482.61(c)(2) What did the patient contribute to the formulation of the treatment plan? Goals of treatment? Is there evidence that the patient was afforded the opportunity to participate in his/her plan of care? Do all treatment team members document their observations and interventions so that the information is available to the entire team?

Swim Lane:

Role(s): Care Team
Department(s):
Security Position(s):

Work Step [18]

Description: Collaborate with patient to develop to schedule outpatient support, if applicable as per organization.

Work Step [19]

Description: Patient is scheduled into group sessions.

Work Step [15]

Description: Patient provided discharge summary with any scheduled appointments/follow-ups.

Comments: Active treatment is an essential requirement for inpatient psychiatric care. Clarification of the types of notes found in the medical record. Treatment notes are recordings in the medical record that indicate provision of, and a patient's response to, a specific modality. This modality may be drug therapy, individual, family, marital, or group therapy, art therapy, recreational therapy, and any specialized therapy ordered by the physician or anyone credentialed by the facility, in accordance with the State

law, to write orders in the medical record. A combined treatment and progress note may be written. Progress notes are recordings in the medical record that are written by persons directly responsible for the care and active treatment of the patient. Progress notes give a chronological picture of how the patient is progressing toward the accomplishment of the individual goals in the treatment plan. These are frequently shift notes, weekly notes, or monthly notes. B139 §482.62(a)(3)Provide active treatment measures; Treatment interventions need to be individualized, in that the patient receives assistance with resolving or ameliorating the problems/circumstances that led to hospitalization. Expect to see treatment focused on the unique needs of individual patients. For example, several patients may be referred to "Anger Management Group," but the focus of discussion and therapeutic intervention may differ depending on the individual patient's particular issue regarding managing anger. Probes §482.62(a)(3) Does the patient attend therapies that are relevant to the identified problems that brought the patient to the hospital? Does the scheduling of activities and their content relate directly to the patient's treatment objectives or are the activities/content generalized, non-therapeutic "time-fillers"?