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ORIGINAL PAPER

# American Association of Community Psychiatrists Position Statement: Putting Patients First by Improving Treatment Planning and Reducing Administrative and Clinical Burden of Treatment Plan Documentation

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## Abstract

This paper represents a position statement of the American Association of Community Psychiatrists (AACP) regarding treatment plans. We regard treatment plans, a documentation requirement, in this position statement, as distinct from the process of treatment planning. The AACP is concerned that treatment plan documentation in its current state, creates unnecessary administrative burden for physicians, without evidence of benefit for patients, reducing direct patient contact time, thereby negatively impacting quality of care. In this position, we echo the statements made by the American College of Physicians in their position paper entitled "Putting Patients First by Reducing Administrative Tasks in Health Care". We recommend a review of the treatment plan documentation requirement across the nation, engaging consumers, providers, regulatory agencies in all states, as well as national reimbursement and regulatory agencies, in order to promote the process of quality driven care and documentation.

**Keywords** Position statement · Treatment plans · Administrative burden · Quality driven care

## Background

In May 2017, the American College of Physicians published a seminal position paper in the Annals of Internal Medicine. The Position Paper was entitled: *Putting Patients First by Reducing Administrative Tasks in Health Care*. The first two recommendations in this position paper included the following language:

1. … (Administrative) tasks that are determined to have a negative effect on quality and patient care, unnecessarily question physician and other clinician judgment, or increase costs should be challenged, revised, or removed entirely.
2. … Administrative tasks that cannot be eliminated from the health care system must be regularly, reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved (Erickson et al. 2017).

The American Association of Community Psychiatrists (AACP) applauds the American College of Physicians' Position Statement and its emphasis on changing the extent to which well-intentioned administrative regulations accumulate to the point that they interfere with good clinical care in spite of a lack of evidence that they produce the results they are intended to ensure.

This issue is of tremendous relevance in behavioral health, particularly in community behavioral health organizations. Administrative burden in community behavioral health services is especially concerning in services that are already extremely stretched for resources. Further, excessive administrative burden directly affects community psychiatrists, contributing substantially to the burnout of, as well as to barriers to recruitment and retention of, psychiatrists in public behavioral health settings. Most importantly,

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excessive administrative burden interferes with the ability of community psychiatrists and community behavioral health organizations to “put patients first” and provide the most effective possible clinical care.

## Focus on Treatment Plan Documentation as Distinct from Treatment Planning

In this position statement, we aim to build on the thrust of the argument made by the American College of Physicians and focus specifically on one important area of regulation that is of significance to community psychiatrists, which is the documentation of “Treatment Plans” in order to meet regulatory requirements.

In this document, we are explicitly distinguishing the essential *clinical* process of treatment planning, which is especially important when working with individuals who have complex care needs or who are receiving complex team-based services, from the specifically prescribed regulatory *documentation* requirement known as the “Treatment Plan.”

Describing all the elements of appropriate clinical treatment planning is beyond the scope of this position paper. Clinical treatment planning in community psychiatry has been well described in the literature (Adams and Grieder 2014) and is continually being studied and improved. Effective treatment planning includes elements such as person/family-centered collaboration with shared decision-making, recovery/resiliency-oriented goals, integrated service delivery, team-based interventions, achievable and realistic objectives, and measurable results.

Further, effective clinical treatment planning must be documented in such a way that it can be useful to people receiving services and all members of the treatment team, as well as to funding and regulatory organizations. However, current documentation requirements do not appear to be an effective and efficient way of meeting that goal.

## Assertions

- We assert that there is no clear evidence that the current requirements for treatment plan documentation and attestation (signature) meet the needs of service recipients, service providers, and funders/regulatory organizations in the most effective and efficient manner.
- We assert that regulatory requirements for provision of behavioral health services in community behavioral health organizations are imposed in a manner that is excessive compared to the requirements for provision of comparable behavioral health services in health clinics.
- We assert that the utilization of treatment plan documentation as the mechanism for determining whether services are eligible for payment interferes with the quality of treatment planning and with the quality of services delivered.
- We assert that the current regulatory requirement of treatment plan documentation as a mechanism for determining reimbursement is additional undue burden for mental health providers when compared to reimbursement policies for chronic medical conditions
- We assert that because the current administrative requirements for documenting treatment plans very commonly “have negative effects on quality and patient care” and unnecessarily “increase costs” without demonstrable value in improving the quality of clinical treatment planning, that these treatment planning documentation requirements need to be “reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved” (Erickson et al. 2017).

## History

Requirements for documentation of “Treatment Plans” originally arose many decades ago for good reasons.

One reason was the serious issue of people being warehoused in state mental health institutions without evidence of adequate treatment, and federal courts subsequently requiring that state institutions provide treatment, and concomitantly requiring written documentation of both the individualized treatment plan and of actual care being provided (Wyatt v Stickney 1971).

Another reason was associated with the expansion of Medicaid funding to community behavioral health services, also in the 1970s. When Medicaid became an important funding stream for public and community behavioral health services, state Medicaid authorities required documentation of “Treatment Plans” and associated treatment interventions as a way of initially establishing mechanisms for confirming “medical necessity” to justify payment.

Since that time, the documented “Treatment Plan” has become entrenched in public and community behavioral health care service delivery. The reach of the “Treatment Plan” has extended to the point that in almost all care settings, community psychiatrists and treatment team members experience such documentation exercises as a detraction from more actual, meaningful treatment planning and direct care activities. After 40 years, a regulatory process such as this is long overdue for critical analysis and reconsideration.

## Challenges

To summarize: The process of *meaningful* treatment planning is an essential aspect of care delivery in public and community behavioral health care settings. Unfortunately, that process is typically not well-captured or well-served by the current regulatory "Treatment Plan" documentation requirement, which:

1. *Lacks sufficient data to justify its continuation as a regulatory requirement*. While there is no doubt that the original concept of the "Treatment Plan" was reasonably intentioned, literature search finds no formal review of the current treatment plan documentation process nor definitive findings that indicate that the process is producing clinically effective treatment planning in all the treatment settings to which it is applied. A review of the literature reveals that numerous publications detail how to write a Treatment Plans (Adams and Grieder 2014; Kennedy 2003). Treatment Plan documentation is embedded into CMS and JCAHO regulatory requirements for inpatient and outpatient services (The Joint Commission 2018). Yet there is no convincing published data suggesting that perpetuation of the currently implemented Treatment Plan requirement improves clinical outcomes or reduces health care costs.
2. *Is a requirement unique to behavioral health care services*. Comparable services (e.g., a physician evaluation and medication visit) for psychiatric conditions in other medical settings, such as primary care, do not have a comparable administrative documentation requirement, with its regulatory and reimbursement implications. The Mental Health Parity and Addiction Equity Act ("MHPAEA") states that Plans may not apply any financial requirement or treatment limitation to Mental Health/ Substance Use Disorders benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification (Mental Health Parity and Addiction Equity Act of 2008 2013). Requiring—as a condition of payment—treatment plans that are substantially longer and more burdensome for mental illnesses and substance use disorders in a mental health clinic than for either psychiatric conditions or medical conditions in a health clinic (where documentation of treatment plans and interventions in a progress note is adequate) is a potential violation of at least the spirit if not the letter of MHPAEA.
3. *Conflates clinical treatment planning with payment authorization creating direct and indirect barriers to access to care*. In most states, counties, and jurisdictions, services that are not specifically delineated on "Treatment Plans" are not reimbursed. The assumption by regulatory entities (such as JCAHO, state Medicaid agencies) is that failure to precisely document the so-called "medical necessity" of each intervention in the required Treatment Plan format is an indication that a service was either not indicated (not medically necessary) or not supposed to be delivered. In some instances, lack of timely completion of the "Treatment Plan" can disqualify consumers from receiving real-time, necessary services (such as functional support services). In many states and in many types of services, unless the "Treatment Plan" is meticulously and perfectly completed, then a given service will not be paid for, or may be subsequently denied. As a consumer's care needs may quickly change, and often expand, the process of keeping the "Treatment Plan" updated in real time before a specific service can be rendered presents a barrier to timely service delivery, while exposing an agency to risk of nonpayment or recoupment.
4. *Targets a payor, rather than a consumer/provider, audience*. The "Treatment Plan" is initiated, updated, and completed with regulatory reviewers and auditors in mind. By contrast, good clinical treatment planning entails a comprehensive process of engagement between the service recipient, family members and treatment team members, is done in language understandable to all involved, and honors the service recipient's unique circumstances and needs. In contrast to formulaic and constrictive regulatory template completion, useful treatment planning in community behavioral health settings is an interactive process that is recovery-oriented, collaborative (engaging consumer and team members in development and follow-through), concise, current and relevant to the consumer's current condition and circumstances, and transferrable across care settings. Good treatment often involves standard monitoring of treatment outcomes, through scales and measures supported in the scientific literature, that both providers and consumers can utilize to track treatment outcomes. Documentation of treatment planning for measurement-based care, as well as the associated monitoring of progress, often takes place and should take place real time in progress notes or a similarly dedicated area in the record, rather than in cumbersome forms that are designed for auditor review rather than for patient care.
5. *Presents undue administrative burden to providers*. "Treatment Plans" demand detailed information entry, including "measurable" "goals" and "objectives." These documents must be signed by the consumer, staff, sometimes family, and a physician. The process of initiating, completing, and updating a Treatment Plan is time- and resource-intensive. Documenting "Treatment

Plan" requirements that meet "audit standards" stands to detract from actual quality treatment planning and execution. Furthermore, the accepted standard of care in health care in general is that treatment planning is documented as an integral component of strong progress notes by those providing care, and so the requirement to separately document a "Treatment Plan" potentially represents duplication of effort and information. Despite the mandate for "meaningful use" electronic health records (EHRs) (Blumenthal and Tavenner 2010), providers utilizing EHRs may face challenges in the integration of the required "Treatment Plan" into other areas of clinical documentation, yielding replication of documentation in disparate areas of the medical record.

6. *Impacts the role of the psychiatrist in the health care team*. At a time when physician shortages are a widespread problem in the workforce, it is critical that physicians practice at the top of their expertise and licensure and limit their involvement in unnecessary administrative tasks as referenced above. The "Treatment Plan" requirement that has been imposed upon the treatment team structure can shift the physician into role of "attestor" and "authorizer" of service, often spending hours signing hundreds of charts of patients that often have not been directly seen and evaluated. This detracts from the community psychiatrist's ability to engage in the role of healer, collaborator, and partner in care delivery. Meaningful physician engagement positively impacts outcomes. Therefore, regulatory requirements that result in physician disengagement from care, without demonstrable value, result in poorer outcomes, and potentially increased burnout and turnover of providers.

## Position

1. The AACP endorses the Position Statement of the American College of Physicians: "Putting Patients First by Reducing Administrative Tasks in Health Care" (Erickson et al. 2017), including the statement that *Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved.*
2. The AACP calls for the immediate elimination of the requirement that provision of a psychiatric visit in a behavioral health clinic necessitates documentation of a formal "Treatment Plan," while provision of a comparable service in other medical settings (such as a primary care clinic) does not have a comparable requirement and requires only documentation in an assessment and progress note. Any similar additional examples of differential documentation requirements for treatment plans, whether for psychiatrists or other behavioral health practitioners, should be immediately identified and eliminated.
3. The AACP calls for elimination of the utilization of elaborate documentation of "treatment plans" as the major vehicle for determining whether services are authorized for payment. Documentation of medical necessity for payment authorization must be simplified and disconnected from clinical treatment planning documentation whenever feasible.
4. The AACP calls for a national collaborative effort—including, but not necessarily limited to, organizations such as CMS, DOJ, SAMHSA, NASMHPD, NACBHD, National Association of State Medicaid Directors, The Joint Commission, CARF, Council on Accreditation, the National Council, and national professional organizations to formally review the pervasive "Treatment Plan" documentation requirements in the delivery of behavioral health care services. Such an effort would include collection and analysis of data about financial, time, and quality of care impact statements of such requirements, and data on correlation (if any) between such requirements and successful clinical treatment planning and service delivery outcomes. Finally, such an effort must include specific recommendations for how to make changes in current documentation requirements, disconnect such requirements from micromanagement by payers, and propose pilot studies or field testing of new standards to determine whether any recommended changes improve clinical efficiency and outcomes while maintaining appropriate levels of clinical and financial accountability.

## Compliance with Ethical Standards

**Conflict of interest** There are no conflicts of interest to report for this position statement.

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