**CLINICAL STANDARD FOR ASSESSMENTS IN CCBH**

The electronic health record (EHR) is a valuable resource for maintaining a centralized single medical record for all client clinical information. During the course of treatment, a client may accumulate multiple Behavioral Health Assessments (BHAs), Psychiatric Assessments, and/or Discharge Summaries. The system was designed to prepopulate or “pull-forward” information from certain fields in these assessment types from the most recent version into a newly opened version. This represents both an opportunity and a challenge.

Given that a client can have multiple historical assessments, it is helpful if the most current clinical information that prepopulates can be readily available for review when opening a new BHA, Psychiatric Assessment and/or Discharge Summary. Practically speaking, however, all information that prepopulates should not be summarily retained as portions of the assessments have become excessively long and have begun to lack clinical precision in describing the client’s current needs. Since all historical information that has been final approved in these assessment types in CCBH exists for review at any time (for those who have access to the client’s EHR), it is not necessary to retain all information that prepopulates in every section of an Assessment.

In 2011, the Clinical Standards Committee created standards addressing information that prepopulates into CCBH Assessments. In an effort to maintain the best clinical practice, these clinical standards have been revised by Quality Management to provide further direction on addressing information which prepopulates when adding new assessments in CCBH.

When a Client is New to Your Program

When adding a new assessment (BHA or Psychiatric Assessment) for a client that is new to your program and information has prepopulated from historical assessments, it is your responsibility to review each section in detail with the client for continued clinical relevance/accuracy. It is not required to keep all historical information in a section. Rather it is your responsibility to add, update, edit, correct, and/or retain appropriate clinical information that, in your professional opinion, is deemed relevant to the client’s current presentation/needs. You may delete information that has pre-populated for the purpose of greater accuracy in documentation of client’s current level of functioning and need. (Please note, this information will always exist in the final approved version of the Assessments previously conducted and documented in CCBH).

Standards for Specific Fields in the BHA and/or Psychiatric Assessment

1. Presenting Problem: Information that pre-populates the Presenting Problem section should be reviewed and summarized, as appropriate, as your first entry in the Past Psychiatric History section. Once summarized, the Presenting Problem information that has prepopulated should be deleted so that the Presenting Problem information documented by you is specific to why the client is seeking services from your program at the time of the assessment.

B. Clinical Formulation: The Clinical Formulation section should be reviewed and summarized with information added to the Past Psychiatric History section, as needed. Then any prepopulated information in this section should be deleted so that the documentation in that section can refer specifically to your program, documenting clearly your assessment of medical necessity and the client’s need for services at your program.

C. The following additional fields have been identified as areas in which historical information should be evaluated for inclusion, revision or deletion (when it makes clinical sense to do so):

* 1. Past Psychiatric History
	2. Family History
	3. Educational/Employment History
	4. Cultural Information
	5. Social History
	6. History of Violence
	7. Trauma questions
	8. Substance Use Information
	9. Military History

Documentation Standards to Indicate Information in a Section of the BHA/Psychiatric Assessment is Being Retained or Edited

When adding to a text field, start your documentation at the beginning of the text window. Label the field with the unit/subunit number of your program to indicate which program is providing information. Additionally, add the date of your documentation. If the information that prepopulated is still current and well documented, and you are accepting the information without changes, type the heading “REVIEWED WITH NO CHANGES” at the top of the previous text. If you want to add to or edit the existing information, type the heading “REVIEWED WITH EDITS” on top of the previous text and then proceed with adding your new information. Please note: your signature on an assessment for a client that is new to your program indicates that you have reviewed all information, made the appropriate clinical revisions, additions and/or deletions, and are in agreement with the assessment.

When Adding Information to an Assessment for a Current Client:

Assessments are meant to be “living documents” in that new information may be added over the course of services as new information or clinical formulations become available. If you have conducted the most recent assessment and are familiar with the client, it is not necessary to review each section in the entire Assessment. Rather, you may update just the sections for which you have knowledge of new information. Follow the documentation standards for labeling/dating the field you are changing as described in the paragraph above.

Concurrent Programs

There are times when a client is open to two programs at the same time. In this instance, it may be appropriate to leave relevant information from the other program in the Clinical Formulation section. If a provider decides to do this (and their BHA is completed subsequent to the other program) their portion of the Clinical Formulation should be documented at the top of the text box and begun by listing their unit/subunit. To delineate the concurrent program’s Clinical Formulation information, their section should end with the following statement: “Information below is retained as the client is concurrently receiving services from another program.”

Similarly, when adding information for a current client who is being seen in another program concurrently, a program may wish to retain information throughout the BHA without making changes to it. When this is the case, the program should delineate the other program’s information by documenting “Concurrent program information reviewed with no edits.”

Procedure: Documentation in Discharge Summaries

Documentation in Discharge Summaries should always be specific to your program and the services your program provided to the client. It is not necessary to retain any information in the narrative text fields of the Discharge Summary that have prepopulated. Delete information that has prepopulated and write only information specific to your program in each narrative section.

For questions about these documentation standards or the procedures outlined above, please email the QI Unit at QIMatters.hhsa@sdcounty.ca.gov