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ASHRM Behavioral Health Care in the Ambulatory Care/Outpatient Setting

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INTRODUCTION

Behavioral health disorders include both mental illness and substance use disorders. Mental illnesses are specific, diagnosable disorders characterized by intense alterations in thinking, mood and/or behavior over time. Substance use disorders are conditions resulting from the inappropriate use of alcohol or drugs, including medications. Persons with behavioral health care needs may experience either or both types of conditions as well as physical co-morbidities.

Patients with behavioral health disorders are being treated in every segment of health care, not just the inpatient setting. As the length of inpatient stays in hospitals has decreased for all clinical conditions, including psychiatric and substance use disorders, patients with greater complexity are being treated on an outpatient basis. According to the Association of American Medical Colleges, the United States will see a shortage of up to nearly 122,000 physicians by 2032 as demand for physicians continues to grow faster than supply.[1]

As a result of changing times and limited resources, an evolution in how patients with behavioral health disorders are managed is occurring. There are newer models of care such as collaborative/integrated care, telebehavioral health, and use of technology in treatment including mobile applications. As the need continues to provide behavioral health services to patients and while there are insufficient providers, services will continue to adjust.

Appendix A provides a Checklist for Treating Behavioral Health Patients in the Ambulatory Care/Outpatient Setting. Appendix B lists resources to utilize within the primary care and ambulatory care setting.

Each organization is unique and varies in how services are offered may exist, creating differences in potential liability exposures. Therefore, it is best to seek risk management or legal advice specific to your organization.

BEHAVIORAL HEALTH CARE IN THE AMBULATORY CARE/OUTPATIENT SETTING

Whether through inpatient practices, emergency departments or outpatient settings such as ambulatory care, urgent care or primary care, providers will likely encounter patients who not only have medical concerns, but also behavioral health disorders. One in five adults experience mental health illness, and one in seven adolescents aged 12 to 17 had a major depressive episode in the last year. One-fifth of all primary care visits address mental health care issues.[2]

The move to integrate physical and behavioral health services in the primary care setting is relatively new. Therefore, access to outpatient psychiatric care with a primary care or behavioral health clinician is often limited. While some hospitals and health systems are working to train primary care physicians to recognize the signs of behavioral health disorders, or to embed a behavioral health clinician in the same office as the primary care provider, the majority of primary care clinicians remain isolated and untrained. It is important that the training of primary care providers and scaling the use of embedding behavioral health clinicians continues in order to advance the integration of physical and behavioral health services.

THE RISE OF TECHNOLOGY

In recent years, tremendous growth in the use of technology has occurred in health care. This is also true in outpatient behavioral health care. New types of technologies and applications are available both to patients and providers.

Mobile applications are being used to track anxiety, symptoms of depression and other behavioral health disorders.[3,4] Because providers are the guardians of patient confidentiality, programs or applications they use must comply with Health Insurance Portability and Accountability (HIPAA) and applicable state privacy regulations. Because there is no true oversight of applications by the federal government, providers may have difficulty determining if an application is helpful or harmful.[5] In such cases, providers should seek guidance from legal counsel on whether to use an application with patients.

Providers also are using technology to consult with one another on behavioral health disorders in the outpatient setting. Technologies such as mHealth, Project ECHO, eConsult and others are being used to conduct consultations between providers.[6] These technologies are also being used to provide consultation across state lines or at a distance, and this is only expected to increase.

THE RISE OF TELEBEHAVIORAL HEALTH

Telebehavioral health is an option for those who cannot access outpatient behavioral health services for a variety of reasons including: medical issues, being home bound, distance or lack of transportation. This modality can be provided to patients via technology including video or mobile devices. Telebehavioral health use is rapidly expanding, and psychiatrists are ranked second among medical providers who utilize telemedicine.[7] Demand for services, lack of available providers and increase in insurance reimbursement are among the reasons use of telebehavioral health is on the rise. Specific risk management and legal considerations should be taken into account when engaging in telebehavioral health. These include: privacy and security, licensure, patient safety, informed consent, and whether the patient is located in the same state as the provider. In addition, providers should be aware that rules and regulations applicable to using telebehavioral health with patients may vary by state. See Appendix B for additional resources.

NEW AND EMERGING AREAS: COLLABORATIVE CARE/INTEGRATED CARE MODELS

Because there are more patients who need behavioral health treatment than behavioral health providers, new practice models to better treat the needs of underserved patients are emerging. For example, some primary care offices are now employing or contracting with behavioral health providers (BHPs) or psychiatric providers to consult and/or treat patients. Models vary in structure but can be referred to as collaborative care, integrated care or co-located care. These models have emerged as a comprehensive way to treat patients with behavioral health disorders who are followed in a physician practice setting. Models vary considerably, and there may be a BHP onsite or consultation available via phone or tele-application. Some BHPs may bill for services or see patients, whereas others may strictly provide consultation to the referring provider to more effectively manage the patient's disorders.

While traditional behavioral health care models remain prevalent, collaborative care is expected to grow and evolve as the demand for care exceeds available providers. Further, the Centers for Medicare and Medicaid Services (CMS) are now offering Common Procedural Technology (CPT) codes for psychiatric collaborative care management, enabling offices to bill for services provided.

Various professionals work within behavioral health care models in a variety of ways. Professionals may include primary care providers (PCPs), BHPs and psychiatric consultants. The BHP has specialized education and training in behavioral health, and may be a social worker, nurse or

psychologist. The BHP may work under the oversight of the PCP. The psychiatric consultant may or may not prescribe medications, depending on the model. The treating provider typically bills for services.

Clarity about responsibilities, especially for patient care, and reporting structure is important. This information affects patient care, but can also be critical when an adverse issue results in a lawsuit or board matter. Liability risks may differ depending upon the role a provider plays within the organization and whether he or she provides patient care or oversight.

MANAGING AND PROVIDING TREATMENT WHEN RESOURCES MAY NOT BE AVAILABLE

Historically, primary care practices referred patients with behavioral health disorders to clinicians such as psychiatrists, psychologists or social workers.[8] There are many challenges associated with a referral-based system. These include lack of community resources, patients feeling stigmatized when seeking behavioral health care, patients not having insurance that provides behavioral health coverage, and those with coverage finding the rules too cumbersome and complex. Patients with behavioral health disorders may prefer to be treated by their PCP who they know and trust, and patients who are psychologically stable have better outcomes with their comorbid conditions.[9]

Within a primary care practice, a large percentage of patients will experience more than one behavioral health issue in their lifetime. While some patients will require higher-level psychiatric care, health care providers should not diminish the impact of some behavioral techniques employed in the office setting. According to the Substance Abuse and Mental Health Administration, "Motivational Interviewing is one clinical approach that helps people with mental health and substance use disorders and other chronic conditions such as diabetes, cardiovascular conditions, and asthma make positive behavioral changes to support better health. The approach upholds four principles: expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client's belief s/he can successfully make a change)."[10]

A variety of effective tools, screenings and other interventions that do not always involve prescribing medications are available for primary care providers to help their patients with anxiety, depression and other psychiatric disorders or issues.[11] Primary care providers need to document any behavioral health concerns when using such interventions.

For example, screening for mental illness can help decrease morbidity. In the case of the seriously mentally ill (SMI), life expectancy is significantly reduced largely due to poor control of comorbid medical conditions, increased incidence of tobacco use and lack of primary care.[12] On average, a PCP has a panel of 1,200-2,000 patients with a wide variety of concerns.[13] The PCP has approximately 20 minutes to assess, diagnose and treat the patient, yet over one-third of a PCP's patients will have some type of psychological or psychiatric concern in addition to their comorbid conditions.[14] Screening in a busy practice can seem overwhelming, but practices can leverage technology, empower staff and utilize wellness visits to complete this screening.

The American Academy of Family Physicians (AAFP) provides mental health clinical recommendations and guidelines, which are outlined on their website.[15] These recommendations and guidelines assist primary care providers to understand what is manageable in an office setting and when referral for hospitalization may be necessary.[16]

Primary care providers also should be aware of resources such as inpatient behavioral health facilities. PCPs should develop professional relationships with both inpatient and outpatient psychiatrists, psychologists and other BHPs in the event that treatment referral or consultation is needed.

If the PCP chooses to provide behavioral health care, standards of care must be met. Patients with a history of suicidal or homicidal thoughts or tendencies need to be screened at each visit, and escalation in behavior should be dealt with urgently. PCPs should be aware of when they are at risk of practicing beyond their scope. They should assess and document thoroughly, and refer or seek consultation if necessary.

At times it may be difficult for a PCP to continue to provide behavioral health care to a patient. It is important to understand limitations and when referral to a higher level of care becomes necessary. If a patient presents with a serious risk of threat of harm to self or others, consideration should be given to inpatient commitment. In outpatient settings, police and Emergency Medical Services may need to transfer a patient for further evaluation for inpatient care. It is always preferable that the patient be transferred voluntarily. Should inpatient commitment be indicated, the PCP should be aware of and follow state-specific criteria for initiating commitment proceedings.[17] In the in absence of the patient's ability to make informed decisions for admission, the PCP needs to have a plan to ensure the safety of the patient and staff.

SPECIAL CONSIDERATIONS WITH CHILDREN/ADOLESCENTS

A variety of issues must be considered when treating minors with behavioral health disorders in the outpatient setting. Issues include consent to treatment, prescribing, confidentiality, boundary issues and reporting obligations.

Minors typically cannot consent to treatment. Most states have some exceptions for situations such as behavioral health, substance use or pregnancy. In general, a parent or guardian needs to provide informed consent for treatment. A minor may present for treatment with a grandparent or other relative who may not have authority to consent to treatment. Consent to treatment also may not be clear cut in cases where a minor's parents are divorced, there is a custody dispute or a state agency is involved. When in doubt, an attorney should be consulted.

A wide range of providers may be involved in a minor's care, through school districts and social service or child protection agencies, which can make treating children and adolescents complicated. Where required, it is essential to have proper consent to release information among these providers. A lack of consent to release information to another provider can create the risk of litigation.

Outpatient practices may encounter minors with behavioral health disorders and it is not uncommon for a PCP or pediatrician to prescribe stimulants for Attention Hyperactivity Disorder (ADHD) or antidepressants for depression. Outpatient providers should be aware of special considerations regarding informed consent for medications that have black box warnings. Outpatient providers must be particularly thorough in explaining the use of black box/off-label medications to parents and mature minors. Medications with black box warnings have been approved by the U.S. Food and Drug Administration (FDA) but carry a significant risk of serious or even life-threatening adverse events. For instance, antidepressants have black box warnings that their use may result in an increased risk of suicidal tendencies in children and adolescents. Providers must clearly discuss these risks with parents and mature minors, and document this discussion in the minor's medical record.

Confidentiality is another issue that can frequently arise when treating minors in the outpatient setting. The minor's privacy and confidentiality must be balanced with his or her treatment and age. Providers should be aware of their state's age of consent.

Boundary issues are another consideration when treating minor patients with behavioral health disorders in the outpatient setting. Boundary issues may occur between the patient and the provider and between the patient's parent or guardian and the provider. Attempts by the parent or guardian to invade the relationship between the patient and provider will undermine patient/provider confidentiality.

Providers will often encounter reporting obligations when treating minors for behavioral health in the outpatient setting. For example, a child may disclose or a provider my suspect abuse or neglect. Reporting obligations are state-specific and laws vary. It is important for BHPs to know who is a mandated reporter and requirements for reporting within their state. Some states, for example, require mandated reporters to report abuse that occurred years ago, even when the patient may no longer be a minor. Other states may not require reporting if the patient has reached the age of majority. If a patient lives in a state other than the state in which he or she is being treated, it is important for the BHP to be aware of any obligations that may be required in the patient's home state. When in doubt, BHPs should contact an attorney, risk management professional or the state child abuse/neglect reporting hotline.

SPECIAL CONSIDERATIONS WITH ADULTS AND DISABLED PERSONS

Reporting obligations may vary among states regarding suspected abuse against elders and disabled persons. This may not only include physical abuse, but also financial exploitation or determining when an elder is at risk. BHPs should be aware of applicable rules within their state.

SPECIAL CONSIDERATIONS CONCERNING DOMESTIC VIOLENCE

BHPs should be aware of and keep current about their state laws and regulations for reporting domestic violence incidents, including penalties for failing to report.[18] As a part of ongoing assessment and treatment, it is important that providers inquire about whether the patient feels safe. They should discuss abuse and ensure thorough documentation in the patient's medical record. Reporting obligations also may exist if children, elders or disabled persons live within a home where domestic violence occurs.

SPECIAL CONSIDERATIONS CONCERNING THE ELDERLY POPULATION

Persons who lack capacity to make informed decisions, such as those with dementia, may seek behavioral health care. When these patients require treatment, the health care facility, family or another will need to seek appointment of an alternate decision maker by the court.

Each state has its own rules concerning guardianship and conservatorship. Many states model their rules on the Uniform Probate Code (UPC). The UPC defines an incapacitated person as "an individual who, for reasons other than being a minor, is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance."[19]

Patients may have a temporary medical issue that impacts their ability to make informed decisions, but later resolves with treatment. For example, an elderly patient may present as confused and, upon evaluation, it is determined that the patient has a urinary tract infection. The confusion may

resolve after treatment with antibiotics. In the interim, it will be important for the provider to consult with legal counsel and/or be aware of rules concerning behavioral health treatment, what constitutes an emergency, and whether the patient can be treated with the temporary incapacity to consent.

SPECIAL CONSIDERATIONS FOR PATIENTS WITH DISABILITIES

The Americans with Disabilities Act (ADA), a federal civil rights law, provides protection to those with disabilities in employment, transportation, state and local services, public accommodations, telecommunication and health care accessibility. According to the 2010 U.S. Census, approximately 19% of the population or 56.7 million people have a disability.[20] It is likely that all outpatient providers will treat a patient with a disability. It is important that providers are aware of applicable laws to ensure effective and competent care.

Title III of the ADA applies to places of "public accommodation," which include physicians' offices located in both buildings and private homes.[21] Important regulatory considerations exist, regardless of the size of the ambulatory care/outpatient practice setting. It is important to be aware of obligations in providing care and communicating with patients including when "auxiliary aids," such as translators, are needed to ensure "effective communication;" when reasonable accommodations should be given for service animals;[23] and accessibility requirements for those in wheelchairs or other devices.[24]

ADDITIONAL CONSIDERATIONS

Additional populations may require heightened attention and care; however, detailed analysis exceeds the scope of this publication. Clinicians should be aware of populations such as:

- **Post-Partum Women**. Particular attention should be paid to symptoms of post-partum depression, post-partum psychosis, heightened stress, anxiety or depression. PCPs should employ a set of questions to assess mental status and coping. PCPs also are encouraged to seek consultation and be aware of potential mandated reporting considerations should there be safety concerns for the infant.
- **Individuals/Youth at Risk for Violence**. Pediatricians or PCPs may encounter individuals with violent tendencies or those who have made threats. Mass casualty events have occurred where prior to them the individual(s) involved exhibited signs that if reported could possibly have helped avoid the event. In 75% of youth violence cases, at least one adult expressed behavioral concerns and in 50% of cases, at least two adults expressed concerns over a youth who ended up becoming an offender.[25] A U.S. Secret Service report, Preventing School Shootings, concluded that there is no true profile of a violent youth offender.[26] However, 25% of the student population were identified as having characteristics similar to those of identifiable violent youth offender characteristics.[27] It is important for providers to assess and document patterns of behavior and engage in frank communication with potential youth offenders about access to firearms and thoughts of suicide or depression, to determine indicators of potential violence.[28] Providers should not to take lightly social media posts, passive threats or increased difficulty with others or at school. Referral may be necessary.
- **Human Trafficking**. It is important for providers to be aware of the signs of human trafficking and seek consultation when necessary. Victims of human trafficking may likely be at increased risk for behavioral health disorders such as post-traumatic stress disorder (PTSD), depression and anxiety.[29]
- **Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ)**. There are unique considerations when treating LGBTQ patients in an outpatient practice setting. These individuals may have experienced issues with social discrimination, may have been victims of harassment or abuse, and may have experienced health care discrimination. It is essential that providers treat all patients equally regardless of their sex or gender identity, or sexual orientation.

Providers also should fully assess LGBTQ patients for suicidal tendencies and potential stressors.[30] LGBTQ youth contemplate suicide at approximately three times the rate of heterosexual youth, and 40% of transgender adults reported having made a suicide attempt, with 92% reporting the attempt before the age of 25.[31,32] These individuals may be seen in the outpatient setting for follow-up. LGBTQ youth were approximately five times as likely to require medical treatment as heterosexual youth. Suicide attempts of LGBTQ youth are four to six times more likely to result in injury, poisoning or overdose that would require treatment from a medical provider than such attempts by their heterosexual peers.[33]

- **Veterans**. Approximately 75% or 22 million veterans receive some or all of their outpatient care outside of the United States Veterans Administration (VA) system.[34] It is important that outpatient providers specifically inquire whether a patient is a veteran, or if the patient is a spouse, child or caregiver of a veteran.[35] Physical and psychological symptoms can continue for years after service. It is important for providers to ask about and evaluate additional needs including treatment for depression, anxiety, PTSD and traumatic brain injury. There also may be financial considerations that impact stressors of the veteran patient and or family/caregivers.

SAFETY IN THE PRIMARY CARE PRACTICE SETTING

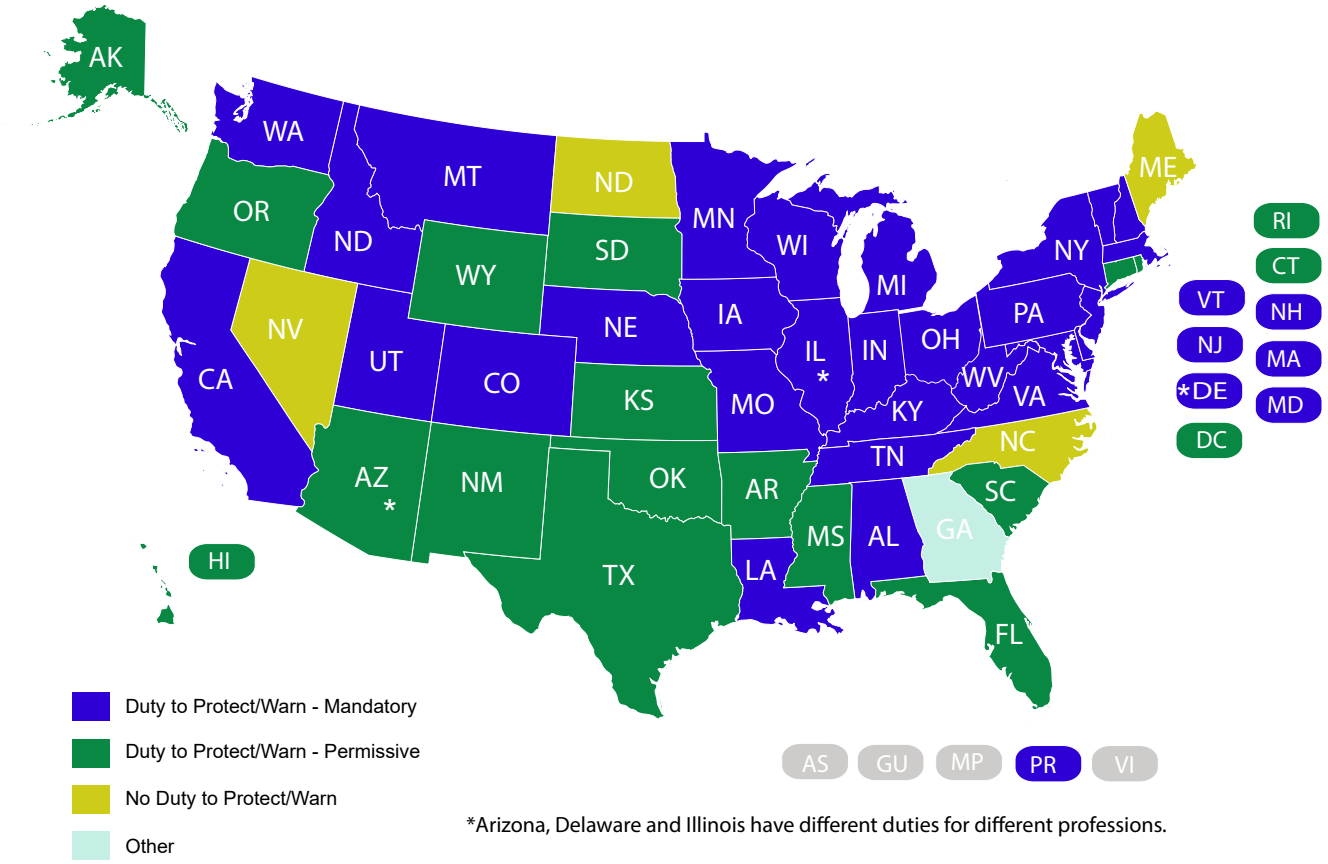
Disruptive behaviors are defined as any behavior that impedes the clinician from providing safe, effective care.[36] These behaviors can contribute to the perception of an environment that is unsafe for staff or other patients.

The ability to recognize escalating signs of agitation and aggression in the ambulatory setting is critical to curtailing potential untoward incidents. Specific stages of behavior escalation could lead to aggression. These stages are: (1) anxiety and agitation-exhibited by loud, fast speech, pacing, clenched fists, angry demands and profanity; (2) verbal threats-posturing, glaring, clenched fists, profanity, invading space, personal threats; and (3) overt aggression including kicking, biting, spitting, damage to property and use of weapons.[37] Strategies to assist with such behavior include training and empowering office staff to help the patient with limit setting and educating the patient and their family on appropriate office behavior and the consequences for not complying.[38] In addition, behavior contracts may be a consideration for patients who continue with disruptive behaviors. If the patient is physically threatening, providers should not hesitate to call 911 or on-site security to assist with de-escalation and transfer to a higher level of care.

DUTY TO WARN/PROTECT

Most providers will, at some point, treat a patient who is at risk of harm to self or others. It is important for all outpatient providers to be aware of whether they have a Duty to Warn/Protect. The Duty to Warn/Protect originates from *Tarasoff v. the Board of Regents of the University of California*, which held a psychotherapist responsible for failing to warn a woman that one of his psychiatric patients had made death threats against her. The patient later killed the woman. Although this case is specific to California, there is case or statutory law for virtually every venue. Significant variations exist in language and about whether a professional is required or permitted to disclose information about a patient who is violent to himself or others. The National Conference of State Legislatures has a complete list of all states' laws. It is important for providers to be up-to-date on the laws in their state pertaining to duty to warn/protect.

Figure 1: Variations in State Duty to Protect/Warn Requirements



Source: http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx

CONCLUSION

The landscape is changing regarding how patients with behavioral health disorders are treated and managed. Patients are increasingly being managed by primary care offices, ambulatory care, integrated care and telebehavioral health methods. It is important that outpatient providers are competent to manage patients effectively, comply with the standard of care, take steps to reduce overall risk and when necessary, obtain outside consultation. Outpatient providers also need to be aware of relevant regulations such as duty to warn/protect and mandated reporting. Because behavioral health care is a specialized area of practice, providers may need to obtain consultation from a risk management or legal professional when questions arise.

APPENDIX A

Checklist for Treating Behavioral Health Patients in the Ambulatory Care/Outpatient Setting*

* *Note: This is a guide to provide resources for clinicians in the ambulatory care/outpatient setting. It is not intended to be a complete resource, but rather to provide tools to assist providers. Should additional assistance be needed, seek advice from a qualified legal counsel or risk management professional.*

Questions	Resources	Y	N
Do you have accurate demographic information for the patient?	https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Collection-Resources-Compendium-2018.pdf		
Do you have accurate demographic information for the patient's family, significant other and emergency contact?	https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html		
Do you have insurance information?	https://www.mentalhealth.gov/get-help/health-insurance		
Have you been in contact to with the patient's insurer regarding mental health benefits including coverage for visits and to obtain billing information?	https://www.apa.org/helpcenter/parity-guide.pdf		
Consent			
Do you have consent to treat mental health disorders for the patient?	https://www.mdedge.com/psychiatry/article/63538/informed-consent-your-patient-competent-refuse-treatment		
Have you obtained release of information from previous mental health provider(s)?	https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html		
Has the patient provided consent for release of information to other physicians/providers?	https://www.ncbi.nlm.nih.gov/books/NBK19829/		
Has the patient provided release of information for his/her therapist?	https://www.mamhca.org/assets/1/7/A._HIPAA_Sample_Standard_Authorization_to_Release_Mental_Health_Treatment_Info_-_MA_Version_11.2014.pdf		
Has the patient provided release of information for family or emergency contact?	https://www.nami.org/find-support/living-with-a-mental-health-condition/what-to-do-in-a-crisis		
Treatment			
Has the psychiatric history & physical and medication reconciliation been completed with effects of psychiatric medication on comorbid conditions noted?	https://www.integration.samhsa.gov/clinical-practice/screening-tools http://lifebalancenw.com/images/site/Adult-intake-form.pdf https://www.ngpg.org/fullpanel/uploads/files/ngpg-psychiatry-new-patient-forms-adult.pdf		

Do prescribed psychiatric medications require laboratory follow-up?	http://web.jhu.edu/pedmentalhealth/images/Monitoring%20Meds.pdf https://www.psychiatrictimes.com/metabolic-monitoring-antipsychotic-medications-what-psychiatrists-need-know/page/0/1		
Does the patient require the AIMS test for extrapyramidal side effects of psychotropics?	https://www.psychiatrictimes.com/tardive-dyskinesia/aims-abnormal-involuntary-movement-scale		
Have you utilized screening tests for the patient at risk of depression or suicide?	www.cqaimh.org › pdf › tool_phq9		
Have you created a safety plan?	https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pd		
Do you need to begin referral for involuntary commitment or obtain a higher level of care?	https://mentalillnesspolicy.org/national-studies/state-standards-involuntary-treatment.html https://www.apadivisions.org/division-31/publications/records/intake http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx		
Special Considerations			
Telebehavioral Health	http://www.ctel.org http://www.ATA.org https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit https://legacy.americantelemed.org/main/policy-page/state-policy-resource-center/additional-state-resources		
Child and Adolescent Treatment	https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Practice_Forms_HIPAA_Disclosures.aspx		
Geriatric Behavioral Health Care	https://www.integration.samhsa.gov/integrated-care-models/older-adults		
Domestic Violence	http://www.nationalcenterdvtraumamh.org/publications-products/information-about-domestic-violence-trauma-and-mental-health/		
Post-Partum Women	https://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression?IsMobileSet=false		
Addiction	https://www.helpguide.org/articles/addictions/substance-abuse-and-mental-health.htm		
Human Trafficking	https://www.dhs.gov/blue-campaign/what-human-trafficking		
LGBTQ	https://afsp.org/about-suicide/lgbtq-suicide-suicide-risk/ https://www.thetrevorproject.org/resources/preventing-suicide/facts-about-suicide/		

Veterans	https://fas.org/sgp/crs/misc/R42747.pdf https://roadhomeprogram.org/		
ADA Considerations	https://adata.org/factsheet/health https://www.hhs.gov/sites/default/files/ocr/civilrights/understanding/disability/adamobilityimpairmentsgudiance.pdf https://www.ada.gov/regs2010/service_animal_qa.html https://www.avma.org/KB/Resources/Reference/AnimalWelfare/Pages/Service-Emotional-Support-Therapy-Animals.aspx		
Mental Health Record Maintenance	https://www.healthit.gov/sites/default/files/appa7-1.pdf		
Mental Health Documentation Sample Audit Tool	https://tuftshealthplan.com/documents/providers/forms/bh-treatment-record-documentation-tool-2015 https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-behavioralhealth-facts		

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