

STANDARDS for TREATMENT RECORD DOCUMENTATION

1. CONFIDENTIALITY: (a) Treatment records are securely stored, (b) only accessible by authorized personnel, and (c) office staff receives periodic training in confidentiality of patient information.

2. PERSONAL/BIOGRAPHICAL INFORMATION: Personal/biographical information shall be documented in a consistent location in the treatment record. Information shall include:

- a. Name or ID number on each page
- b. Date of birth
- c. Home address
- d. Home/work telephone numbers
- e. Gender
- f. Employer or school
- g. Marital or legal status
- h. Appropriate consent forms/guardianship information
- i. Emergency contact information

3. COMPREHENSIVE TREATMENT RECORD ORGANIZATION: A comprehensive treatment record is defined as a single all-inclusive record of health information that is comprised of all clinical patient information available to the Provider, Affiliate, or group practice. The internal information from the Provider or Affiliate office is integrated with external information.

Practices that have satellite offices must have at least one location that maintains a comprehensive treatment record.

All contents of the paper or hard copy treatment record must be in an established format and sequencing, either in chronological or reverse chronological order.

The electronic treatment record may encompass multiple applications to form a comprehensive record (e.g. if demographic information such as home/work phone number are stored in one application, follow-up visit information in another separate from the main EMR, all applications must be accessible to the clinical staff from an individual work station).

4. ALLERGIES: Documentation of medication allergies are clearly noted. If the patient has no known allergies, this must be noted in the treatment record – typically as NKA (no known allergies) or NKDA (no known drug allergies). Physician and Nurse Practitioner records also clearly describe the reactions associated with allergies.

5. SPECIAL STATUS SITUATIONS: Special status situations include conditions where the patient is at imminent risk of harm, has suicidal or homicidal ideation with a plan, or is unable to conduct activities of daily living. Observations of these situations and prompt referral to the appropriate level of care shall be documented in the record.

6. MEDICATION MANGAGEMENT: Records contain information about medication. This information includes:

- a. Medication prescribed or documentation of no medication
- b. Dosages of each medication (physician and nurse practitioner records)
- c. Dates of initial prescription or refills (physician and nurse practitioner records)
- d. Herbal medications or over the counter medications

7. ALCOHOL, TOBACCO, AND SUBSTANCE USE AND/OR ABUSE: Documentation includes past and present use of cigarettes, alcohol, and prescribed, illicit, and over the counter drugs, including frequency and quantity.

8. MENTAL STATUS EVALUATION: The treatment record will contain evidence of at least one mental status evaluation/examination (e.g. patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control).

9. HISTORY: A psychiatric and medical history shall be obtained and documented in the record outlining the patient's past treatment and response (or lack thereof). The history shall consist of:

- a. Previous treatment dates
- b. Therapeutic interventions and responses
- c. Sources of clinical data (e.g. self, mother, spouse, past records)
- d. Relevant family information
- e. Consultation reports, if available/applicable (e.g. psychological testing)
- f. Lab test results, if applicable, in physician and nurse practitioner records (i.e. Lithium, Depakote, Tegretol levels)

10. MINOR PATIENTS TREATMENT RECORDS: Records of minor patients (less than 18 years of age) shall contain documentation of prenatal and perinatal events, complete developmental histories (e.g. physical, psychological, social, intellectual, and academic) and evidence of family involvement in care within 60 days of the initial visit.

11. INITIAL TREATMENT PLAN: Within the first three visits the treatment plan contains (a) specific measurable goals (b) documentation the treatment plan and/or goals were discussed with the patient, (c) have estimated time frames for goal attainment or problem resolution and (d) document the patient's strengths and limitations in achieving goals

12. DIAGNOSIS: The treatment record documents a DSM-IV or ICD-9 diagnosis or clinical impression within the first three visits. "Deferred" or "Rule out" diagnosis is acceptable but must be revised within 3 visits.

13. TREATMENT RECORD NOTES: Each face-to-face encounter note contains (a) objective and subjective documentation of the patient's presentation and (b) updated goals.

14. LEGIBILITY: The treatment record is legible to someone other than the writer.

15. AUTHOR IDENTIFICATION and DATE OF ENTRIES: All entries shall be dated, including the month and year, and have the author's name and professional degree (e.g. PhD, MD, LCSW).

16. FOLLOW UP APPOINTMENTS: The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan. Documentation of follow-up with the patient has occurred if an appointment was missed.

17. CONTINUITY AND COORDINATION OF CARE: As applicable, the treatment record reflects continuity and coordination of care as evidenced by communication with, or review of information from, other behavioral health providers, consultants, ancillary providers, and health care institutions.

18. COORDINATING CARE WITH THE PCP: Physician or Nurse Practitioner treatment records reflects contact with the patient's primary care physician (PCP), as applicable, and follow-up contact as needed.