Behavioral Health Treatment Record Standards

Treatment records must be:

- Accurate and legible,
- Safeguarded against loss, destruction or unauthorized use,
- Maintained in an organized fashion, and readily accessible for review or audit.

The treatment records must include, minimally, the following:

- Member name or ID noted on each page of the record
- Member demographic information including name, date of birth, sex, address, phone, emergency contact, guardianship information noted (for children)
- Primary language spoken by the member and any translation needs of the member
- Treatment Consent forms
- Member Bill of Rights
- Releases of Information for PCP and other involved parties
- Information provided about Psychiatric Advance Directives, as appropriate.
- Initial Evaluation/Assessment including :

  -Presenting problem and Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis

  -Mental health status exam

  -Psychiatric history,

  -Assessment of co-occurring substance use disorder

  -Suicide/risk assessment

  -Assessment of strengths, skills, abilities, etc.

  -Developmental history for children and adolescents

  -Family and social support assessment

  -Member's desired outcomes

  -Medical history, including allergies and adverse reaction

  -Current medication and dosages

  -Preliminary discharge planning

- Individualized Treatment Plan including:
    - -Measurable goals and objectives with time frames for completion
    - -Member participation in treatment planning documented by member's signature
    - -Incorporation of preventive services and member education
- Progress Notes including:
    - -Treatment goals reflected in documentation
    - -Date, begin and end times of service
    - -Documentation supports current level of care
    - -Assessment of member's progress
    - -Continuous substance use assessment, if applicable
    - -Continuous suicide/risk assessment
    - -Medication compliance (if applicable)
    - -Family/support system involvement, preventive services recommended
    - -Discharge planning for alternative or appropriate level of care (when applicable)
- Individualized Crisis plan
- Coordination of Care to include PCP communication and coordination with other involved behavioral health providers, programs or institutions (if applicable)
- Documentation of Medication Management (if applicable)
- Documentation of cultural competency
- Documentation of comprehensive discharge planning
- Documented Clinical Practice Guidelines utilization