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