

**Beacon Comprehensive Behavioral Health Management
Policy and Procedure Manual**

Policy Name: Standards	Treatment Records
Date: 11-97 Reviewed by QI Committee: 5-07, 5-08, 5-09, 5-10, 5-11 Revised by QI Committee: 11-06, 5-09	Page: 1 of 4 Policy Number: TR-1

Purpose: To promote efficiency and effectiveness in treatment, Beacon Comprehensive Behavioral Health Management (Beacon CBHM) requires that all treatment records are maintained within State, Federal, and the National Committee for Quality Assurance (NCQA) guidelines in a manner that is current, comprehensive, detailed, organized and legible.

Policy:

1.0 Overview

- 1.1 The treatment records provide timely documentation of relevant aspects of patient care in evaluation and treatment.
- 1.2 Behavioral health practitioners use treatment records to document patient encounters, including initial telephone assessments, relevant clinical decisions, findings, interventions, and coordination of care.
- 1.3 Treatment records used in quality review, measurement, and improvement activities adhere to standards of confidentiality.

2.0 Guidelines

To ensure complete treatment records, the following documentation guidelines have been established.

- 2.1 Administrative Data
 - 2.1.1 Each page in the treatment record contains the patient's name and identification number.
 - 2.1.2 Each record includes patient address, employer or school, home and work telephone numbers including emergency contacts, marital/legal status, appropriate consent forms, and guardianship information, if relevant.
 - 2.1.3 Each record includes a statement regarding office policies (no shows, late cancellations, emergency contacts, etc) that is signed by patient.
 - 2.1.4 Each record includes documentation of review of patient's rights with the patient.
 - 2.1.5 All entries in the treatment record include the responsible clinician's name, professional degree, and relevant identification number, if applicable.
 - 2.1.6 All entries are dated.
 - 2.1.7 The record is legible.

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- 2.2 Medical and Psychiatric History
 - 2.2.1 Relevant medical conditions are listed, prominently identified, and updated.
 - 2.2.2 A past medical and psychiatric history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.
 - 2.2.3 Allergies and adverse reactions are clearly documented; a lack of known allergies and sensitivities to pharmaceuticals and other substances is also prominently noted.
 - 2.2.4 For children and adolescents, prenatal and perinatal events, and a complete developmental history including physical, psychological, social, intellectual, and academic, are documented.
 - 2.2.5 For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs.
- 2.3 Clinical Assessment
 - 2.3.1 Presenting problems and relevant psychological and social conditions affecting the patients' medical and psychiatric status are documented. Psychosocial history should include current living situation, support systems and legal issues.
 - 2.3.2 Special status situations, such as imminent risk of harm, suicidal ideation, history of non-compliance or elopement potential, are prominently noted, documented, and updated in compliance with written protocols.
 - 2.3.3 A mental status evaluation documents the patient's affect, speech, mood, thought content, judgment, attention/concentration, memory and impulse control/risk management.
- 2.4 Treatment Plan
 - 2.4.1 A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.
 - 2.4.2 Treatment plans are consistent with diagnoses and have objective measurable goals and estimated time frames for goal attainment or problem resolution. For minors, the need for family involvement is documented.
 - 2.4.3 Each record includes documentation of review of treatment plan with the patient.

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- 2.4.4 Each record indicates what medications have been prescribed, the dosages of each medication, and the dates of initial prescription or refills.
- 2.4.5 Psychotherapy is focused on improving functional impairments and relies on brief therapy such as cognitive behavioral therapy. Patients should be given specific homework assignment to achieve treatment goals. Homework progress should be reviewed at each session and documented in the progress note.
- 2.4.6 The focus of treatment interventions is consistent with the treatment plan goals and objectives; informed consent for medication and the patient’s understanding of the treatment plan is documented.
- 2.4.7 Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives.
- 2.4.8 Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.
- 2.4.9 The treatment record documents preventive services as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources.
- 2.4.10 The treatment record reflects continuity and coordination of care between the primary clinician, consultants, ancillary providers, and health care institutions. Refusal of patient to coordinate care is noted as appropriate.
- 2.4.11 The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.

3.0 Special Circumstances

Beacon CBHM recognizes that at times patients discontinue outpatient treatment within one or two sessions or are discharged from inpatient treatment within two to three days. In these circumstances, a treatment record may be brief. However, Beacon CBHM does require that the following minimal documentation be included:

- 3.1 Outpatient Progress Note
 - 3.1.1 Presenting problem
 - 3.1.2 Diagnosis and mental status
 - 3.1.3 Risk factors noted (e.g., suicidal or homicidal ideation)
 - 3.1.4 Treatment interventions offered

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- 3.1.5 Patient response
- 3.1.6 Reason for discharge
- 3.1.7 Follow-up (e.g., written letter or phone call)
- 3.2 Hospital discharge summary
 - 3.2.1 Reason for admission
 - 3.2.2 Admit diagnosis and mental status
 - 3.2.3 Treatment interventions, (e.g., Medications, Therapy modalities, Social Services evaluation)
 - 3.2.4 Response to treatment interventions
 - 3.2.5 Discharge diagnosis and mental status
 - 3.2.6 After care plan, (e.g., Follow-up appointments with PCP, Psychiatrist, Therapist, Social services interventions, Medications)