

Standards for Treatment Records

Initial Evaluation of Treatment Record Keeping Practices

APS has established treatment record keeping standards to assure that its practitioners maintain well-organized treatment records that facilitate communication, yet maintain patient and family confidentiality. These standards are assessed at the time of a site and/or treatment record review. The standards are:

- Each patient has individual folder/chart filed by name or identification number.
- Treatment records must be kept in a locked and secured location within the practitioner's office.
- Any electronic treatment records are secured by unique password for each staff/practitioner.
- There are policies and procedures related to maintaining treatment records in a confidential manner.
- Treatment records are available to the practitioner at the time of treatment
- Treatment records are retained upon discharge in accordance with all state and federal laws.
- Records of practitioners who leave a group practice are completed, promptly filed and retained in safekeeping according to applicable state and federal laws.
- There are policies and procedures related to treatment records.
- Patient consent for release of information or refusal thereof is valid.

An overall score of 80% is required. However, lack of compliance with maintaining treatment records in a secure manner (items 2 and 3 above) is a serious breach. During the review process any office found to be out of compliance with these critical elements will be considered non-compliant for record keeping practices, irrespective of the overall score. In these instances, a request for a corrective action plan will be made, and a reassessment would be made within six months.

Treatment Record Documentation Standards

In addition to initial on-site reviews, APS may also conduct clinical treatment record reviews of practitioners in accordance with NCQA standards.

APS has established treatment record documentation standards and compliance goals for its practitioners. These are intended to assure that APS practitioners maintain well

documented treatment records that facilitate communication, coordination, and continuity of care so to promote efficient and effective care.

APS has established the following standards for treatment record documentation:

1. Each page in the record contains the patient's name or identification number.
2. Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms (including consent for treatment) and guardianship information if relevant.
3. All entries in the treatment record include the responsible clinician's name, professional degree, and relevant identification number if applicable.
4. All entries are dated.
5. The record is legible to someone other than the writer and in ink.
6. Relevant medical conditions are listed, prominently identified, and revised.
7. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
8. Assessment of severity and imminence of potential harm to self or others is completed and documented at least once and then as often as appropriate.¹
9. Special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential, are prominently noted, documented, and revised in compliance with written protocols.
10. Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.
11. Allergies and adverse reactions are clearly documented.
12. A medical and psychiatric history is documented (for example: including previous treatment dates, practitioner identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports).
13. For children and adolescents, prenatal and prenatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic) are documented.

¹CRITICAL INDICATOR

14. For patients 12 and older, documentation includes past and present use of cigarettes, alcohol, illicit drugs, and prescription medication(s).
15. A mental status evaluation documents the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.
16. A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessments.
17. Treatment plans are consistent with diagnoses and have both objective measurable goals and estimated timeframes for goal attainment or problem resolution.
18. The focus of treatment interventions is consistent with the treatment plan goals and objectives.
19. Informed consent for medication and the patient's understanding of the treatment plan is documented. (For MDs/DOs only)
20. Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.
21. The treatment record documents preventive services, as appropriate (e.g., relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources).
22. ² Treatment record provides evidence of practitioner attempting to obtain consent to communicate with other behavioral healthcare practitioners or practitioners when appropriate.
23. ³ Treatment record provides evidence of communication and coordination of care with other behavioral healthcare practitioners or practitioners if they exist.
24. ⁴ Treatment record provides evidence of practitioner attempting to obtain consent to communicate with primary care physician (PCP) or other ancillary practitioners/health care institutions when appropriate.
25. ⁵ Treatment record provides evidence of coordination of care with primary care practitioner (PCP) or other ancillary practitioners/health care institutions when they exist.
26. The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.

² CRITICAL INDICATOR

³ CRITICAL INDICATOR

⁴ CRITICAL INDICATOR

⁵ CRITICAL INDICATOR

Practitioner Communication

APS Treatment Record Documentation Standards and performance goals are distributed to practitioners via the Practitioner Manual, which practitioners receive upon commencement of their contract. Practitioners may also be notified of revisions to the standards or policy through newsletters or other direct mailings.

Performance Monitoring

APS reviews a sample of treatment records on an annual basis. Records are selected from APS enrollees that have started treatment with practitioners during the prior year. To ensure the confidentiality of patient information, APS reviewers or vendors use the following procedures:

- Reviewers are licensed healthcare professionals with a contractual and professional obligation to maintain confidentiality;
 - The practitioner is given advanced notice of the review.
 - The records are reviewed in a private area of the office, and
 - The records remain at the practitioner's office throughout on-site review.
 - The practitioner is requested to blind all patient identifying information for any records submitted to APS for the purposes of treatment record review.

Records being reviewed for other APS quality activities are utilized for completing the annual clinical record keeping monitoring. Other quality activities used for this may include:

- Clinical guideline monitoring
- Clinical study data collection
- Investigation of quality of care issues
- Activities monitoring continuity and coordination of care

Practitioners receive written notification of their results within 90 days of the review. They receive their completed tool along with the record keeping toolkit.

Performance Goals

Compliance with the standards requires an overall score of 60%. Compliance with Critical Indicator #15, assessment of severity and imminence of self harm and requires a score of 80%. Compliance with Critical Indicators 34, 35, 36 and 37 (see –attached Monitoring Tool) requires a score of 60%.

Practitioners who fall below the acceptable threshold (above) may be referred to the appropriate APS quality committee for further review and follow-up.