TUFTS Health Plan

Behavioral Health Treatment Record Documentation Tool 2015

Health Plan: ***Tufts Health Public Plans***

Date of Review: _____ Time of Review: _____

Practitioner Name: _____ Member ID: _____
Office Manager: _____ Member Last Name: _____
Complete Office Address: _____ Member First Name: _____
_____ Member DOB: _____
Telephone Number: _____ Gender: _____
Review Completed By: _____

Outpatient Treatment Record Documentation	YES	NO	N/A
1. Is the record legible to person other than author? Please refer to job aid if answering NO.	☐	☐	☐
If **NO**, explain:			
2. Is the member's name and/or ID number on each page?	☐	☐	☐
If **NO**, explain:			
3. Does the member's name appear in the demographic area?	☐	☐	☐
If **NO**, explain:			
4. Does the member's address appear in the demographic area?	☐	☐	☐
If **NO**, explain:			
5. Does the home phone/cell phone number appear in the demographic area?	☐	☐	☐
If **NO**, explain:			
6. Does the member's name of employer appear in the demographic area (if applicable)?	☐	☐	☐
If **NO**, explain:			
7. Does the member's work telephone number appear in the demographic area (if applicable)?	☐	☐	☐
If **NO**, explain:			

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Outpatient Treatment Record Documentation	YES	NO	N/A
8. Does the member's marital status appear in the demographic area?	☐	☐	☐
If **NO**, explain:			
9. Is the member's D.O.B documented?	☐	☐	☐
If **NO**, explain:			
10. Is the member's primary/preferred spoken language documented?	☐	☐	☐
If **NO**, explain:			
11. Are the member's disabilities documented (if applicable)?	☐	☐	☐
If **NO**, explain:			
12. Is the member's emergency contact information (name/address/phone) documented?	☐	☐	☐
If **NO**, explain:			
13. Are all entries dated?	☐	☐	☐
If **NO**, explain:			
14. Are all entries signed?	☐	☐	☐
If **NO**, explain:			
15. Does the treatment record contain information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)?	☐	☐	☐
If **NO**, explain:			
16. Is there a current medication list with evidence of updates including dosages and dates of initial or refill prescriptions?	☐	☐	☐
If **NO**, explain:			
17. Is there a current and complete problem list including significant illnesses and medical and psychological conditions?	☐	☐	☐
If **NO**, explain:			

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Outpatient Treatment Record Documentation	YES	NO	N/A
18. Does the treatment record contain presenting complaints, diagnoses, and treatment plans?	☐	☐	☐
If **NO**, explain:			
19. Is there documentation of member's past medical history (including significant psychiatric and mental illness)?	☐	☐	☐
If **NO**, explain:			
20. Does the history and psychiatric assessment identify appropriate subjective and objective information pertinent to the member's presenting complaints?	☐	☐	☐
If **NO**, explain:			
21. Is there documentation of the member's treatment plan?	☐	☐	☐
If **NO**, explain:			
22. Is there evidence that unresolved problems from previous office visits were addressed in subsequent visits (if applicable)?	☐	☐	☐
If **NO**, explain:			
23. Does the record includes sufficient information identifying dates of encounters and pertinent information documenting the member's diagnosis(es)?	☐	☐	☐
If **NO**, explain:			
24. Is there documentation of member's necessary treatments and possible risk factors for the member relevant to the particular treatment?	☐	☐	☐
If **NO**, explain:			
25. Is there evidence that the member was involved in his/her plan of care?	☐	☐	☐
If **NO**, explain:			
26. Is there a completed Child and Adolescent Needs and Strengths (CANS-MA version) assessment for members age 20 and under, including the initial Behavioral Health Clinical Assessment and, at a minimum, every 90 days thereafter during ongoing treatment?	☐	☐	☐
If **NO**, explain:			
27. Is a developmental history included for members 13 years old and younger?	☐	☐	☐
If **NO**, explain:			

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28. Is there evidence of communication/collaboration with the member's PCP for continuity of care?	☐	☐	☐
If **NO**, explain:			
29. Is there evidence of a substantive substance abuse assessment (other than Y/N) including: past/present use of cigarettes; alcohol; and illicit, prescribed, and over-the-counter drugs?	☐	☐	☐
If **NO**, explain:			
30. Is there any evidence of under- or over-utilization of specialty services or pharmaceuticals?	☐	☐	☐
If **NO**, explain:			
31. Is there documentation that laboratory and other studies were ordered, as appropriate?	☐	☐	☐
If **NO**, explain:			
32. Is there evidence that laboratory and imaging reports filed in the chart are initialed by the provider who ordered them to signify review?	☐	☐	☐
If **NO**, explain:			
33. Is there evidence that there has been contact with the member's family, guardian, or significant other (mandatory if member is under 16)?	☐	☐	☐
If **NO**, explain:			
34. Is there is evidence of communication with state agencies; the Department of Children and Families (DCF), the Department of Mental Health (DMH), the Department of Youth Services (DYS), and/or the Department of Developmental Services (DDS), if applicable?	☐	☐	☐
If **NO**, explain:			
35. Is there evidence that follow-up care was provided when indicated (e.g., calls, visits, tests)?	☐	☐	☐
If **NO**, explain:			
36. Is there evidence of the follow-up plan including time of return noted in weeks or months, or return as needed?	☐	☐	☐
If **NO**, explain:			
37. Is there evidence of discussion and instructions on Advance Directive wishes, and/or a completed and signed Advance Directive?	☐	☐	☐
If **NO**, explain:			

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Confidentiality (Attestation)	YES	NO	N/A
38. Did the Provider return a signed Attestation form confirming that the treatment records are in a space staffed by office personnel?	☐	☐	☐
If **NO**, explain:			
39. Did the Provider return a signed Attestation form confirming that the treatment records are in a locked office when the staff is not present?	☐	☐	☐
If **NO**, explain:			
40. Did the Provider return a signed Attestation form confirming that they prohibit unauthorized review and/or removal of treatment records?	☐	☐	☐
If **NO**, explain:			
41. Did the Provider return a signed Attestation form (with a copy of the office's policy) confirming that they maintain and adhere to policies and procedures regarding patient confidentiality (HIPPA)?	☐	☐	☐
If **NO**, explain:			

Comments: