

	Rec 1	Rec 2	Rec 3	Rec 4	Rec 5	Comments
10. A medical and psychiatric history is documented in the treatment record, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.						
11. For enrollees 12 and older, documentation in the treatment record includes past and present use of cigarettes and alcohol, as well as illicit, prescribed, and over-the-counter drugs. NA if the enrollee is under the age of twelve.						
12. A mental status evaluation that includes the patient's affect, speech, mood, thought content, judgement, insight, attention, concentration, memory, and impulse control is documented in the treatment record.						
13. A DSM-IV/ICD9 diagnosis, consistent with the presenting problems, history, mental status examination, and/or other assessment data is documented.						
14. Treatment plans are consistent with diagnoses and have both objective measurable goals and estimated time frames for goal attainment or problem resolution.						
15. The focus of treatment interventions is consistent with the treatment plan goals and objectives.						
16. Each treatment record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills. For non-prescribing practitioners, each treatment record indicates what medications have been prescribed and the name of the prescriber. N/A if medications are not prescribed.						
17. Informed consent for medication and the patient's level of understanding is documented. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (i.e., MD).						
18. When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (i.e., MD).						
19. Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives.						
20. Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care. N/A if the patient is not homicidal, suicidal, or unable to conduct activities of daily living.						
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. The treatment record documents dates of follow-up appointments or, as appropriate, a discharge plan.						
23. The assessment is culturally relevant (addresses issues relevant to the patient's race, religion, ethnicity, age, gender, sexual orientation, level of education, socioeconomic level, etc.)						
24. The treatment plan is culturally relevant (addresses issues relevant to the patient's race, religion, ethnicity, age, gender, sexual orientation, level of education, socioeconomic level, etc.).						
25. Evidence of coordination with the PCP or declination of this by the patient.						
26. The treatment record reflects continuity and coordination of care between health care institutions, ancillary providers, and/or consultants						

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27. The treatment record reflects evidence of coordination of care with other outpatient behavioral health practitioners.						
28. The treatment record reflects evidence of coordination with the EAP/employer if a referral was made.						
Child and Adolescent Records Only - Numbers 29 - 33						
29. For children and adolescents, prenatal and perinatal events, along with a complete developmental history including physical, psychological, social, intellectual, and academic are documented in the treatment record. N/A if the patient is over the age of 18.						
30. The record reflects the active involvement of the family/primary guardian in the assessment and treatment of the patient, unless contraindicated.						
31. The record indicates the parent(s) or guardian(s) have given signed consent for the various treatments provided.						
32. The record indicates an assessment of school functioning.						
33. The record indicates evidence of coordination with the youth's school to achieve related treatment goals.						
Clinical Practice Guideline Adherence						
Data related to these adherence indicators is used only in the aggregate - it does not enter into the total score/evaluation of the records of this individual practitioner but the results are shared with the practitioner						
MAJOR DEPRESSION - 296.2, 296.3						
Mood symptoms and suicidality are assessed at every visit						
Co-morbid problems are assessed upon initial evaluation and at least annually.						
When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g. MSW, PhD)						
SCHIZOPHRENIA - 295 Series						
There is evidence of an assessment of positive signs of psychosis, e.g., delusions and/or hallucinations.						
Co-morbid problems are assessed upon initial evaluation and at least annually						
When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g., MSW, PhD)						
When anti-psychotic medications are prescribed, there is evidence of observation for side effects including EPS such as dystonic reactions, akathisia, ("can't sit still"), or akinesia. {Note: this applies to all discipline levels; N/A may not be checked}						

	Rec 1	Rec 2	Rec 3	Rec 4	Rec 5	Comments
ADHD – 314.00; 314.01; 314.9 SERIES						
The record reflects the active involvement of the family/primary caretakers in the assessment and treatment of the enrollee, unless contraindicated. N/A is scored if contraindicated.						
When medication is prescribed, there is evidence of consistency among the signs and symptoms, diagnosis, and medication prescribed. N/A is scored if medication is not prescribed or the practitioner being reviewed is not a prescriber (e.g., MSW, PhD)						
When medication is prescribed, there is evidence of an evaluation of the enrollee's response to medication and adjustments as needed.						
Bipolar Disorder – 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.89 Series						
Mood symptoms and suicidality are assessed at every visit.						
Co-morbid problems are assessed upon initial evaluation and at least annually.						
When medications are prescribed that require serum level monitoring and/or laboratory tests to screen for medication side effects, those tests are conducted as recommended by the drug manufacturer. N/A is scored for non-prescribing practitioners (e.g. MSW, PhD)						
Co-Occurring Psychiatric and Substance Related Disorders						
List Two – Substance Abuse Diagnoses:						
Psychoactive Substance						
Intoxification or Withdrawal 292.xx						
Psychoactive Substance Induced Disorders 292.xx						
Psychoactive Substance Dependence 304.xx						
Psychoactive Substance Abuse 305.xx						
Follow-up after discharge from inpatient care within 7 days						
Treatment plan includes identification of barriers to adherence and interventions that address these barriers.						
Treatment plan includes relapse plan, including identification of relapse triggers, skills needed to deal with triggers, and contingency plan for difficult instances						
Treatment plan includes both SA and psychiatric issues and interventions						