Treatment and Supervision Documentation Checklist

This is a tool to support behavioral health providers with documentation.

General

- ☐ Record is legible
- ☐ Consumer name or ID number noted on each page of record
- ☐ Entries are dated and signed by appropriately credentialed provider
- ☐ Record contains relevant demographic information including address, employer/school, phone, emergency contact, marital status

Consumer Rights and Confidentiality

- ☐ Signed treatment informed consent form, or refusal documented
- ☐ Patient Bill of Rights signed, or refusal documented
- ☐ Psych advance directives, or refusal documented
- ☐ Informed consent for medications signed, or refusal documented
- ☐ Release(s) for communication with PCP, other providers and involved parties signed, or refusal documented

Initial Evaluation

- ☐ Reason member is seeking services (presenting problem) and mental health status exam
- ☐ DSM-5TR/ ICD-10-CM diagnosis
- ☐ History and symptomatology consistent with DSM-5/ICD-10-CM criteria
- ☐ Psychiatric history
- ☐ Co-occurring (co-morbid) substance induced disorder assessed
- ☐ Current and past suicide/danger risk assessed
- ☐ Assessment of consumer strengths, skills, abilities, motivation, etc.
- ☐ Level of familial/supports assessed and involved as indicated
- ☐ Consumer identified areas for improvement/outcomes documented
- ☐ Medical history
- ☐ Exploration of allergies and adverse reactions
- ☐ All current medications with dosages
- ☐ Discussion of discharge planning/linkage to next level

Individualized Treatment Plan

- ☐ Individualized strengths-based treatment plan is current
- ☐ Measurable goals/objectives documented
- ☐ Goals/objectives have timeframes for achievement
- ☐ Goals/objectives align with consumer identified areas for improvement/outcomes
- ☐ Use of preventive/ancillary services including community and peer supports considered

Ongoing Treatment

- Documentation substantiates treatment at the current intensity of support (level of care)
- Progress towards measurable consumer identified goals and outcomes evidenced; if not, barriers are being addressed
- Clinical assessments and interventions evaluated at each visit
- Substance use assessment is current/ongoing
- Comprehensive suicide/risk assessment is current/ongoing
- Medications are current
- Member compliance or non-compliance with medications is documented; if non-compliant, interventions considered
- Evidence of treatment being provided in a culturally competent manner
- Family/support systems contacted/involved as appropriate/feasible
- Ancillary/preventive services considered, used, and coordinated as indicated
- Crisis plan documented
- Discharge planning/linkage to alternative treatment (level of care) leading to discharge occurring

Addendum for Special Populations

- Guardianship information noted
- Developmental history for children and adolescents
- If member has substance use disorder, there is evidence of Medication Assisted Treatment or discussion of it.

Addendum for NCQA Site Only

- Records are stored securely
- Only authorized personnel have access to records
- Staff receive periodic training in confidentiality of member information
- Treatment records are organized and stored to allow easy retrieval

Coordination of Care

- Evidence of provider request of consumer for authorization of PCP communication
- Evidence consumer refused authorization for PCP communication
- PCP communication after initial assessment/evaluation
- Evidence of PCP communication at other significant points in treatment, e.g., medication initiated, discontinued, or significantly altered; significant changes in diagnosis or clinical status; at termination of treatment
- Treatment Record reflects continuity and coordination of care between

primary behavioral health clinician and (note all that apply under comments): psychiatrist, treatment programs/institutions, other behavioral health providers, ancillary providers

Evaluation of Treating Provider Communication (Example: Communication with Primary Care Physician)

- ☐ Accuracy: Communication matched information in chart
- ☐ Timeliness: Communication within 30 days of initial assessment
- ☐ Sufficiency: Communication appropriate to condition/treatment
- ☐ Frequency: Occurred after initial assessment
- ☐ Frequency: Occurred after change in treatment/medications/risk status
- ☐ Frequency: Occurred after termination of treatment
- ☐ Clarity: Reviewer understands communication

Medication Management

- ☐ Completed medication flow sheet or progress note includes documentation of current psychotropic medication, dosages, date(s) of dosage changes
- ☐ Documentation of member education regarding reason for the medication, benefits, risks, and side effects (includes effect of medication in women of childbearing age, and to notify provider if becomes pregnant, if appropriate)
- ☐ Documentation of member verbalizing understanding of medication education

Supervision Documentation

- ☐ Date of supervision session
- ☐ Name of supervisee or supervisees, if group supervision
- ☐ Duration/length of time in supervision
- ☐ Include ID numbers of patients discussed and outcome/next steps for each patient, if casing specific patients
- ☐ Any other content of the supervision session for their supervisee(s) which may include a professional development plan
- ☐ All documents pertaining to clinical supervision will be readily available to the supervisee

Please note this is a tool and not an exhaustive list of all treatment and supervision documentation requirements. Providers should refer to their governing and regulatory documents including but not limited to the New Mexico Behavioral Health Policy and Billing Manual: For Providers Treating Medicaid Beneficiaries and the New Mexico Administrative Code (NMAC) to ensure all requirements for treatment and supervision documentation are being met.