NY SUD Outpatient Treatment Record Tool

Effective Date: September 20, 2025

General Documentation

Question	
1	Each member has a separate record.
2	Treatment record that includes the member's address, telephone numbers including emergency contacts, birth and/or identified gender, relationship and legal status, and guardianship information, if relevant.
3	All entries in the record include the responsible clinician's name, professional degree/licensure/certification, and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.
4	For children and adolescents the record includes legal documents (court mandates, parental custody, ACS/CPS custody, orders of protection, termination of parental rights etc.) confirming a child's legal custodian AND legal guardian (if different).

Initial Assessment

Question	
5	The initial assessment for outpatient services is completed within 30 days of the member's request for services; any exceptions to this time frame are clearly documented (must be scored for all outpatient services).
6	A complete clinical case formulation is documented in the record (e.g., DSM primary treatment diagnosis, medical conditions, psychosocial and environmental factors and functional impairments) including a behavioral health/substance abuse treatment history as appropriate.
7	The member's reasons for seeking treatment are documented.
8	There is documentation that recent providers of services have been contacted to obtain discharge summaries and other pertinent information.
9	A medical assessment/physical examination is in the record, has been completed within the last year and includes known medical conditions, current treating clinicians and current medications.
10	Was a current medical condition identified? This is a non-scored question.
11	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. This is a non-scored question.
12	If a medical condition was identified, there is documentation that the member/guardian refused consent for the release of information to the treating medical clinician. This is a non-scored question.
13	If the member has not had a physical exam in the last year, or the member was not assessed by a medical staff there is evidence that the member was referred to a physical exam.
14	The admissions process includes screening for co-occurring mental health conditions using an OASAS approved screening tool
15	The record documents a risk assessment appropriate to the level of care and population served which may include the presence or absence of suicidal or homicidal risk and any behaviors that could be considered a danger toward self or others.
16	If a risk issue is identified, a safety plan is documented in the record.
17	The record includes documentation of previous suicidal or homicidal behaviors, (dates, method, and lethality) as well as any behaviors that could be considered a danger toward self or others.
18	The behavioral health history includes an assessment of any abuse the member has experienced or if the member has been the perpetrator of abuse.
19	For children and adolescents the assessment includes and assessment of bullying the member has experienced or if the member has been the perpetrator of bullying.
20	The behavioral health history includes an assessment of any trauma the member has experienced.

21 For Adolescents: The assessment documents a sexual behavior history to include sexual identity, orientation, activity status, unsafe/risky situations and practices.

22 For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, living arrangements, custody, and academic), are documented.

23 For members 12 and older, a substance abuse screening occurs using a standardized screening instrument and clinical assessment as needed. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.

24 For members 12 and older, the substance abuse screening includes documentation of past and present use of nicotine.

25 For active smokers, the substance abuse screening includes documentation of the member's readiness to reduce or quit using tobacco.

26 For active smokers, every 3 months the member's nicotine use is reassessed.

27 For members under the age of 18, the substance abuse screening includes documentation of nicotine, alcohol or substance use by anyone living in the member's place of residence.

28 If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.

29 The substance identified as being misused was alcohol. This is a non-scored question.

30 The substance(s) identified as being misused were substance(s) other than alcohol. This is a non-scored question.

31 The substances identified as being misused were alcohol and other substance(s). This is a non-scored question.

32 The assessment documents the spiritual and cultural variables that may impact treatment

33 An educational assessment appropriate to the member's age is documented (including identification of any literacy needs).

34 The record documents the presence or absence of relevant legal issues of the member and/or family.

35 There is documentation that the member was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.

36 There is documentation that indicates the member understands and consents to the medication used in treatment.

37 For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.

38 Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.

39 The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.

40 The member's previous medication history is documented in the record.

41 The clinician uses a Consent for Treatment or Informed Consent form with all members; this document should be signed by the member and/or legal guardian.

42 For children and adolescents, there is documentation that the legally authorized decision maker for the child understands and consents to treatment.

Coordination of Care

Question

43 Does the member have a medical physician (PCP)? This is a non-scored question.

44 The record documents that the member was asked whether they have a PCP. Y or N Only

45 If the member has a PCP there is documentation that communication/collaboration occurred.

46 If the member has a PCP, there is documentation that the member/guardian refused consent for the release of information to the PCP.

47	Is the member being seen by another behavioral health provider (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). This is a non-scored question.
48	The record documents that the member was asked whether they are being seen by another behavioral health provider. Y or N Only
49	If the member is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.
50	If the member is being seen by another behavioral health provider, there is documentation that the member/guardian refused consent for the release of information to the behavioral health provider.

Treatment Planning

Question	
51	There is evidence that the treatment plan begins at the time of the initial assessment and includes initial services to be offered prior to completion of the initial assessment.
52	If member receiving services from collateral organizations or providers (such as: probation, family court, domestic violence support, etc.) there is evidence that, when agreed upon by the member, that communication occurs as needed.
53	There is evidence that member and the primary clinician develop the treatment plan collaboratively based on goals identified during the assessment process.
54	For children and adolescents, there is evidence that the legally authorized decision maker and member work collaboratively with the primary clinician to develop a treatment plan based on goals identified during the assessment process.
55	The treatment plan includes a recovery goal in the member's own words.
56	The treatment plan identifies a single member of the clinical staff responsible for coordinating and managing the patient's treatment who shall approve and sign such plan.
57	The treatment plan will be incorporated into the patient record through regular progress notes.
58	The treatment plan has estimated time frames for goal attainment.
59	The identified interventions in the treatment plan are appropriate for the member based on their diagnosis and goals identified through the assessment process.
60	For members that are pregnant or become pregnant, evidence of development of a plan of safe care is offered.
61	For a member that is pregnant or becomes pregnant in care: the treatment/recovery plan must include provisions for pre-natal care or if the patient refuses or fails to obtain such care, the patient should acknowledge in writing that pre-natal care was offered, recommended, and refused.
62	There is evidence that the assessment is used in developing the treatment plan.
63	At the time of the initial assessment and throughout treatment, potential barriers or difficulties to participating in treatment are identified and addressed.
64	The treatment/recovery plan is reviewed through the ongoing assessment process and regular progress notes.
65	When applicable, the treatment record, including the treatment plan, reflects transition planning.
66	If a member is receiving services in a group setting, there is evidence of an individualized assessment, treatment planning, and progress notes in response to identified member needs.
67	The treatment record indicates the member's involvement in care and service.
68	When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.

Progress Notes

Question	
69	For all Outpatient Services: All progress notes document the start and stop times or duration for each session when a timed code is used.
70	For all Outpatient Services: All progress notes document clearly who is in attendance during each session.

71	For all Outpatient Services: All progress notes include documentation of the billing code that was submitted for the session.
72	The progress note indicates the type of intervention that was used for the session
73	The progress notes reflect reassessments when necessary.
74	The progress notes reflect on-going risk assessments (including but not limited to suicide, homicide, and dangerous behaviors) and monitoring of any at risk situations.
75	Documentation in the record reflects that safety plans are reviewed and updated when clinically indicated.
76	The progress note includes recommendations, coordination of care, and up-dates of initial, continued or revised patient goals and/or treatment as needed.
77	The progress note documents member progress toward implementation of the treatment plan.
78	The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.
79	The progress notes document the use of any preventive services (relapse prevention, stress management, wellness programs and referrals to community resources).
80	If the member is on medication, there is evidence of medication monitoring in the treatment record. (physicians and nurses)
81	When a primary care physician is identified, there is evidence the prescriber coordinated care within 14 calendar days after initiation of a new medication. This is a non-scored question.
82	The progress notes document the dates of follow up appointments AND when members miss appointments.
83	When a member misses an appointment, there is documentation of outreach efforts (phone calls, missed appointment letters) the provider makes to reengage the member in treatment.

Transition Planning

Question	
84	Was the member transferred/discharged to another clinician or program? This is a non-scored question.
85	If the member was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.
86	If the member was transferred/discharged to another clinician or program, there is documentation that the member/guardian refused consent for release of information to the receiving clinician/program.
87	The reason for transition/discharge is clearly identified.
88	The transition/discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.
89	The transition plan must be developed in collaboration with the patient and any collateral person(s) the patient chooses to involve. Such plan shall specify needed referrals with appointment dates and times, all known medications (including frequency and dosage) and recommendations for continued care.
90	When a member discontinues services, a full review of the case, including an assessment of the level of risk, is completed and efforts are made to reengage the member in services.
91	When a case is closed as a result of the member discontinuing services, written correspondence is sent to the member indicating they are encouraged and welcome to reengage in services at any time.

Treatment Records

Question	
92	The record is clearly legible to someone other than the writer.
93	When appropriate there is evidence of supervisory oversight of the treatment record.

Education

Question	
94	There is documentation that the provider offers education to members/families about care options, participation in care, coping with behavioral health problems, prognosis and outcomes.
95	There is documentation that the risks of not participating in treatment are discussed with the member.

Interpreter Services

Question	
96	If the member has limited English proficiency, there is documentation that interpreter services were offered.

Recovery and Resiliency

Question	
97	The member is given information to create psychiatric advance directives. This is a non-scored question.