December-16

Optum - Behavioral Network Services

CASE MANAGEMENT RECORD AUDIT TOOL

Facility Name:

Reviewer Name:

Date of Facility Review:

	Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
	General Documentation Standards			
1	Each client has a separate record.			
2	Each record includes the client's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
3	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.			
4	The record is clearly legible to someone other than the writer.			
5	There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the client and/or legal guardian.			
6	There is documentation that the service provider provides education to client/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.			
7	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian.			

Initial Assessment				
8	The reasons for initiation of services are documented.			
9	A psychiatric diagnosis is included in the record.			
10	A behavioral health history is in the record.			
11	A medical history and/or physical exam, along with documentation of any infectious diseases, is in the record.			
12	Was a current medical condition identified? **This is a non-scored question. (If #11 is no, then 12 is NA)**			
13	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. **This is a non-scored question.**			
14	If a medical condition was identified, there is documentation that the patient/guardian refused consent for the release of information to the treating medical clinician. **This is a non-scored question.**			
15	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
16	The assessment documents the spiritual variables that may impact services			

17	The assessment documents the cultural variables that may impact services			
18	An educational assessment appropriate to the age of the consumer and level of service is documented.			
19	There is documentation of an assessment of the consumer's level of functioning in the domains of Activities of Daily Living.			
20	For clients 12 years and older, a screening is in evidence of use or exposure to alcohol, nicotine, and/or illicit drugs.			
21	The record documents the presence or absence of relevant legal issues of the patient and/or family.			
22	There is documentation that the patient was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.			
23	There is documentation of a screening for risk issues in the record.			
24	When risk issues are identified, there is evidence that an initial safety plan has been developed.			
Service Planning				
25	There is evidence that the results of the assessment are considered in the development of the service plan.			

26	The service plan is consistent with diagnosis and has objective and measurable short and long term goals.			
27	The service plan includes a safety plan when active risk issues are identified.			
28	There is evidence the service plan was reviewed with and agreed upon by the consumer.			
29	There is evidence that the service plan is reviewed and updated at regular intervals.			
Progress Notes				
30	All progress notes include the date of service.			
31	All progress notes include the time of service provided.			
32	All progress notes include who is present for services.			
33	Progress notes include assessment of how the consumer is progressing with service plan goals.			
34	All progress notes include who rendered services.			
35	The progress notes document on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.			

36	Progress notes include an ongoing assessment of the consumer's capacity to complete ADL's.			
37	As appropriate, progress notes document assessment of any additional services needed by the consumer.			
Coodination of Care				
38	Does the client have a medical physician (PCP)? **This is a non-scored question.**			
39	The record documents that the client was asked whether they have a PCP. **Y or N Only**			
40	If the client has a PCP there is documentation that communication/collaboration occurred.			
41	If the client has a PCP, there is documentation that the client/guardian refused consent for the release of information to the PCP.			
42	Is the client being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
43	The record documents that the client was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			
44	If the client is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
45	If the client is being seen by another behavioral health clinician, there is documentation that the client/guardian refused consent for the release of information to the behavioral health clinician.			

Discharge and Transfer

46	Was the client transferred/discharged to another clinician or program? **This is a non-scored question.**			
47	If the client was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
48	If the client was transferred/discharged to another clinician or program, there is documentation that the client/guardian refused consent for release of information to the receiving clinician/program.			
49	Prompt referrals to the appropriate level of care are documented when client cannot be safely treated at their current level of care secondary to homicidal or suicidal risk or an inability to conduct activities of daily living.			
50	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
51	The discharge/aftercare/safety plan describes specific follow up activities.			
52	Clinical records are completed within 30 days following discharge.			