December-16

Optum - Behavioral Network Services

TREATMENT 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 admission or initiation of treatment are indicated.			
9	A complete clinical case formulation is documented in the record (e.g., primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments)			
10	An initial primary treatment diagnosis is present in the record.			
11	A behavioral health history is in the record.			
12	A medical history and/or physical exam (appropriate to the level of care) is in the record.			
13	Was a current medical condition identified? **This is a non-scored question. (If #14 is N, then #15 and 16 are N/A)**			
14	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. **This is a non-scored question.**			
15	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.**			
16	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			

17	A complete mental status exam is in the record, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.			
18	The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.			
19	The medical treatment history includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses.			
20	The behavioral health treatment history includes family history information.			
21	The medical treatment history includes family history information.			
22	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, danger toward self or others.			
23	The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.			
24	The behavioral health history includes an assessment of any abuse the member has experienced or if the member has been the perpetrator of abuse.			
25	For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.			

26	For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.			
27	The initial screen includes an assessment for depression.			
28	The assessment documents the spiritual variables that may impact treatment			
29	The assessment documents the cultural variables that may impact treatment			
30	An initial treatment plan is established at each level of care with goals, treatment priorities, and milestones for progress is in the record.			
31	An educational assessment appropriate to the age and level of care is documented.			
32	The record documents the presence or absence of relevant legal issues of the patient and/or family.			
33	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.			
34	There is evidence that the assessment is used in developing the treatment plan and goals.			
35	For patients 12 and older, a substance abuse screening occurs. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.			

36	For patients 12 and older, the substance abuse screening includes documentation of past and present use of nicotine.			
37	If the screening indicates an **active** alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.			
38	The substance identified as being misused was alcohol. **This is a non-scored question.**			
39	The substance(s) identified as being misused were substance(s) other than alcohol. **This is a non-scored question.**			
40	The substance(s) identified as being misused were alcohol and other substance(s). **This is a non-scored question.**			
Treatment Planning				
41	There is documentation (a signed form or in progress note) that the patient or legal guardian (based on each state's age of consent) has agreed to the treatment plan.			
42	The treatment plan is consistent with diagnosis and has objective and measurable short and long term goals.			
43	The treatment plan has estimated time frames for goal attainment.			
44	The treatment plan includes a safety plan when active risk issues are identified.			

45	The treatment plan is updated whenever goals are achieved or new problems are identified.			
46	The treatment plan is reviewed and updated with the patient at regular intervals.			
47	When applicable, the treatment record**, including the treatment plan,** reflects discharge planning.			
48	If a patient is receiving group therapy, there is evidence of an individualized assessment, treatment planning, and progress notes in response to identified patient needs.			
49	The treatment record documents and addresses biopsychosocial needs.			
50	The treatment record indicates the patient's involvement in care and service.			
51	When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.			
Progress Notes				
52	All progress notes document the length of service rendered when providing a timed service. (outpatient services)			
53	All progress notes document clearly who is in attendance during each session. (outpatient services)			

54	All progress notes include documentation of the billing code that was submitted for the session. (outpatient services)			
55	The progress notes reflect reassessments when necessary.			
56	The progress notes document on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.			
57	The progress notes describe/list patient strengths and limitations and how those impact treatment.			
58	The progress notes describe progress or lack of progress towards treatment plan goals.			
59	The progress notes document the dates of follow up appointments.			
60	The progress notes document when patients miss appointments.			
61	The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.			
62	When appropriate there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)			
Medication Management				

63	There is documentation that indicates the patient understands and consents to the medication used in treatment.			
64	For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.			
65	Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.			
66	If the patient is on medication, there is evidence of medication monitoring in the treatment record. (physicians and nurses)			
67	When lab work is ordered, there is evidence the lab results were received and reviewed by the clinician.			
68	When the patient is on medications, the prescribing clinician documents that the patient was provided with education about the risks, benefits, side effects, and alternatives of each medication.			
69	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.**			
	If there is evidence of coordination of care outside of 14 calendar days, document how many days after initiation the coordination took place.			
Coordination of Care				
70	Does the patient have a medical physician (PCP)? **This is a non-scored question.**			
71	The record documents that the patient was asked whether they have a PCP. **Y or N Only**			

72	If the patient has a PCP there is documentation that communication/collaboration occurred.			
73	If the patient has a PCP, there is documentation that the patient/guardian refused consent for the release of information to the PCP.			
74	Is the patient being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
75	The record documents that the patient was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			
76	If the patient is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
77	If the patient is being seen by another behavioral health clinician, there is documentation that the patient/guardian refused consent for the release of information to the behavioral health clinician.			
Discharge and Transfer				
78	Was the patient transferred/discharged to another clinician or program? **This is a non-scored question.**			
79	If the patient was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
80	If the patient was transferred/discharged to another clinician or program, there is documentation that the patient/guardian refused consent for release of information to the receiving clinician/program.			

81	Prompt referrals to the appropriate level of care are documented when patients 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.			
82	For all discharged patients, the discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
83	For all discharged patients, the discharge/aftercare/safety plan describes specific follow up activities.			
84	Clinical records are completed within 30 days following discharge.			
Recovery and Resiliency				
85	The patient is given information to create **psychiatric** advance directives. **This is a non-scored question.**			
86	The patient is provided with referrals to peer support services. **This is a non-scored question.**			
Inpatient/Residential/Partial/IOP				
87	The record documents functional impairments preventing completion of activities of daily living, assessment of fall risk, and elopement risk.			
88	There is evidence of patient monitoring appropriate to their level of acuity.			
89	There is clear documentation of medication dispensing, as appropriate.			

90	**For Detox Services,** there is evidence of consistent documentation of vital signs throughout treatment.			
91	There is evidence of progress documented by the physician/addictionologist at regular intervals, appropriate to the rendered service.			
92	**For eating disorder treatment**, there is evidence of medical monitoring at appropriate intervals to the level of care throughout treatment.			
California Specific				
93	For California Only: If the patient has limited English proficiency, there is documentation that interpreter services were offered.			
94	For California Only: If interpreter services were offered, there is documentation indicating whether the patient accepted or declined the services.			