July-19

Optum Idaho - Behavioral Network Services

BMC 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 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	An initial primary treatment diagnosis is present in the record, including who gave the diagnosis, and any diagnostic report leading up to the ASD diagnosis.			
9	There is evidence of a functional behavioral or skills-based assessment, as appropriate, is in the record.			
10	Prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.			
11	The initial assessment screens for any current behavioral health conditions.			
12	The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.			
13	The initial assessment screens for any current medical conditions.			
14	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.			
15	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
16	The record includes a thorough assessment of targeted risk behaviors which includes harm to self or others.			

17	The record includes a history of any previous services received, for behavioral health or other intensive autism related services, including dates of service.			
18	The behavioral health treatment history includes family history information.			
19	The medical treatment history includes family history information.			
20	When appropriate, there is evidence of an IEP in the record, or documentation of other school-based interventions.			
21	The assessment documents the spiritual variables that may impact treatment			
22	The assessment documents the cultural variables that may impact treatment			
23	An educational assessment appropriate to the age and level of care is documented.			
24	The record documents the presence or absence of relevant legal issues of the client and/or family.			
25	There is documentation that the client and/or family was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.			

Service Planning				
26	The service plan is consistent with diagnosis and has objective and measurable short and long term goals.			
27	The service plan is reviewed and updated with the patient at regular intervals.			
28	The service plan shows evidence of moving toward discharge.			
29	There is evidence that the service plan is reviewed on a regular basis.			
Progress Notes				
30	Daily notes measure patient response to intervention in specific programs.			
31	There is evidence of patient response to interventions related to targeted behaviors.			
32	Documentation of the place of service is in the service note.			
33	It is clear in the daily notes who rendered the services.			
34	The length of time of service is clearly documented in the service note.			
35	The service notes clearly document that targeted risk behaviors are monitored and addressed.			

36	There is evidence of notes documenting communication with parents/guardians.			
37	There is documentation of parent/caregiver training at regular intervals and on an ongoing basis.			
38	There is documentation of who is in attendance at the session (parents, other children, BCBA, etc).			
39	The record, including the service plan, reflects discharge planning.			
40	There is evidence of regular direct observation/supervision.			
41	There is evidence of specific service notes of supervision/direct observation in the record.			
Coodination of Care				
42	Does the client have a medical physician (PCP)? **This is a non-scored question.**			
43	The record documents that the client was asked whether they have a PCP. **Y or N Only**			
44	If the client has a PCP there is documentation that communication/collaboration occurred.			

45	If the client has a PCP, there is documentation that the client/guardian refused consent for the release of information to the PCP.			
46	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.**			
47	The record documents that the client was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			
48	If the client is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
49	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				
50	Was the client transferred/discharged to another clinician or program? **This is a non-scored question.**			
51	If the client was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
52	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.			
53	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.			

54	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
55	The discharge/aftercare/safety plan describes specific follow up activities.			
56	Clinical records are completed within 30 days following discharge.			