Optum - Behavioral Network Services

Program Quality Improvement Self Assessment Tool - Individual Practitioner

	Present in Chart?	Y	N	NA
General Documentation Standards				
	Each participant has a separate record.			
	The record includes the participant's gender (assigned and/or identified), address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
	All entries in the record include the responsible service provider's name, title and credentials, and are dated and signed (including electronic signature for EMR systems), where appropriate.			
	The record is clearly legible to someone other than the writer.			
	There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the participant or parent/legal guardian, in advance of treatment.			
	The record contains legal documentation to verify that the consent was given by the appropriate person.			
	The record contains documentation that the service provider provides education to participant/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.			

	The record contains documentation that the provider informed the participant of the purpose and nature of an evaluation or treatment process.			
	The record contains documentation that the provider informed the participant of the additional options to the proposed treatment.			
	The record contains documentation that the provider informed the participant of the potential reactions to the proposed treatment.			
	The record contains documentation that the provider informed the participant of the right to withdraw from treatment at any time, including the possible risks that may be associated with withdrawal.			
	The record contains documentation that the provider informed the participant of the fees for service, including that Maryland Medicaid are exempt from any additional out-of-pocket fees.			
	For participants with a PCP: If a medical physician (PCP) is identified, the record contains a signed Release of Information, or refusal to give consent to communicate/collaborate with the PCP.			
	For participants with an identified medical condition in the assessment: The record contains a signed Release of Information, or refusal to give consent to communicate/collaborate with the treating medical provider.			
	For participants being prescribed medication by this provider: The record contains documentation that the provider educated the participant or parent/legal guardian about the risks, benefits, side effects, and alternatives of each medication, and the participant or parent/legal guardian understands the medication(s) being prescribed.			
	For participants receiving substance use treatment from this provider: The record contains a completed Maryland Medicaid/Maryland Department of Health/Optum Maryland *Authorization to Disclose Substance Use Treatment Information for Coordination of Care* form, or documentation that the participant refused to sign the form.			

For uninsured participants: The record contains a completed MDH *Documentation for Uninsured Eligibility Registration* form, and verification of uninsured eligibility status or documentation of approval by MDH to bill uninsured.			
For participants being seen by another behavioral health provider: The record contains a signed Release of Information, or refusal to give consent to communicate/collaborate with the behavioral health provider.			
For participants discharged to another provider: The record contains a signed Release of Information, or refusal to give consent to communicate/collaborate with the receiving provider.			
For participants seen via telehealth/telephonic means: The record contains documentation that the participant or parent/guardian was fully informed of the terms, limits, security-confidentiality risks of HIPAA-compliant and non-HIPAA-compliant telehealth and/or telephonic service transmission.			
For participants seen via telehealth/telephonic means: The record contains evidence of Informed Consent obtained by the participant and/or legal guardian, specific to each type of transmission (telehealth; telephonic).			
For participants seen via telehealth/telephonic means: If the platform to be used is non-HIPAA-compliant, the consent documentation explicitly states that the participant or parent/legal guardian understands and accepts the risks associated and consents to receive services via non-HIPAA-compliant transmission.			
For participants seen for group sessions via telehealth/telephonic means: The record contains documentation that the participant will receive services in a private space where no one can overhear sessions.			
Psychologist and Counselor Specific			
For Psychologists and Counselors involved in research: The record contains an Informed Consent that is signed by the participant or parent/legal guardian to participate in research, in advance of treatment.			

	For Psychologists and Counselors involved in research: The record contains Informed Consent documentation that the provider clearly indicated to the participant the nature of participation, that treatment is given as part of a research study.		
	For Psychologists and Counselors involved in research: The record contains Informed Consent documentation that the provider informed the participant of the right to decline treatment, if part or all of the treatment is to be recorded for research or review by another person, and does not imply that a penalty may result in refusal to participate.		
	For Psychologists and Counselors involved in research: The record contains Informed Consent documentation that the provider informed the participant that permission will be obtained prior to electronic recording or observation by another person.		
	For psychologists: The record documents the participant's original test data with results and other evaluative material.		
	For psychologists: The record documents the results of any formal consultations with other professionals.		
Initial Assessment			
	The record contains an individualized assessment, completed by the provider.		
	The assessment includes the participant or family's presenting problem.		
	The assessment includes the participant or family's history.		
	The assessment includes the diagnosis, based on DSM-V.		

The assessment includes a rationale for the diagnosis.			
The assessment contains a complete mental status exam.			
The record contains documentation of the participant's medical history.			
The medical history includes family history information.			
The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.			
Was a current medical condition identified?			
For participants with an identified medical condition: There is documentation that communication/collaboration with the treating medical provider occurred.			
For participants with an identified medical condition: There is documentation that the participant or parent/legal guardian refused consent for the release of information to the treating medical provider.			
The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.			
The behavioral health treatment history includes family history information.			

	The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.			
	The medical treatment history includes family history information.			
	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.			
	The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.			
	For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.			
	For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.			
	The assessment includes an assessment for depression.			
	The assessment documents the spiritual variables that may impact treatment			
	The assessment documents the cultural variables that may impact treatment			
	An educational assessment appropriate to the age and level of care is documented.			
	The record documents the presence or absence of relevant legal issues of the participant and/or family.			

	There is documentation that the participant was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.			
	For participants 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.			
	For participant 12 and older, the substance use screening includes documentation of past and present use of nicotine.			
	If the screening indicates an **active** alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.			
	The substance identified as being misused was alcohol.			
	The substance(s) identified as being misused were substance(s) other than alcohol.			
	The substance(s) identified as being misused were alcohol and other substance(s).			
	The record contains reassessments, when necessary.			
Treatment Planning				
	An initial treatment plan is established at each level of care.			
	Each treatment plan (initial and update) is individualized.			

There is evidence that the assessment is used in developing the treatment plan and goals.			
Each treatment plan (initial and update) states the participant's problems.			
Each treatment plan (initial and update) states the participant's needs.			
Each treatment plan (initial and update) states the participant's strengths.			
Each treatment plan (initial and update) has objective and measurable short and long term goals.			
Each treatment plan (initial and update) includes estimated time frames for goal attainment.			
Each treatment plan (initial and update) includes medically necessary interventions.			
When applicable, the treatment plan reflects discharge planning.			
The record indicates the participant's involvement in treatment planning.			
When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.			

	The treatment plan is reviewed and updated with the participant or parent/legal guardian (if applicable) at regular intervals.			
	The treatment plan is updated whenever goals are achieved or new problems are identified.			
	Each treatment plan review documents progress towards goals.			
	The record includes a safety plan, completed with the participant, when active risk issues are identified.			
	Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.			
	Each treatment plan (initial and reviews) are signed by the provider.			
Progress/Contact Notes				
	All progress/contact notes document the start time and end time the service was rendered.			
	All progress/contact notes document the location where service was rendered.			
	All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.			
	All progress/contact notes document clearly who is in attendance during each session.			

	All progress/contact notes document the participant's mental status.			
	All progress/contact notes contain a summary of interventions.			
	The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).			
	The progress/contact notes describe progress or lack of progress towards treatment plan goals.			
	The progress/contact notes reflect reassessments, when necessary.			
	The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).			
	The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.			
	The progress/contact notes document the dates of follow-up appointments.			
	The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.			
Evaluation and Management (E&M) - Physicians and Nurse Practitioners only				
	Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.			

	If the participant was prescribed a controlled substance, there was evidence in the record the prescriber utilized the Chesapeake Regional Information System for our Patients (CRISP) prior to prescribing.			
	If the participant is on medication, there is evidence of medication monitoring in the treatment record.			
	When lab work is ordered, there is evidence the lab results were received and reviewed by the prescribing provider.			
Coordination of Care				
	The record documents that the participant was asked whether they have a medical physician (PCP).			
	Does the participant have a PCP?			
	If the participant has a PCP, there is documentation that communication/collaboration occurred.			
	The record documents that the participant was asked whether they are being seen by another behavioral health provider.			
	Is the participant being seen by another behavioral health provider?			
	If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.			
Discharge and Transfer				
	Was the participant transferred/discharged to another clinician or program?			

	If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
	The record documents prompt referrals to the appropriate level of care are documented when participant 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.			
	For all discharged participants, the discharge summary documentation is comprehensive.			
	For all discharged participants, the discharge plan describes specific follow-up activities.			
	Clinical records are completed within 30 days following discharge.			