Optum - Behavioral Network Services

Program Quality Improvement Self Assessment Tool - SUD Program

	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 participant over the age of 18 was given information on, or declined assistance with making an advance directive.			
	The record contains documentation that the participant received infectious health education.			
	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 has been informed of the security-confidentiality risks related to this form of transmission, understands and accepts the risks, 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.			
Initial Assessment			
The record contains an individualized assessment.			
The assessment includes the participant's presenting problem.			
The assessment contains a comprehensive history.			
The assessment includes the diagnosis, based on DSM-V.			

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 clinician 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 clinician.			
The record contains documentation of the participant's behavioral health treatment history.			
The behavioral health treatment history includes family history information.			
The behavioral health history includes an assessment of any abuse the member has experienced or if the member has been the perpetrator of abuse.			

	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.			
	The assessment documents the spiritual variables that may impact treatment			
	The assessment documents the cultural variables that may impact treatment			
	The assessment documents a recommendation for appropriate level of substance use disorder treatment.			
	The participant meets ASAM criteria for the recommended level of substance use disorder treatment.			
	The participant is enrolled in the recommended level of substance use treatment.			
	The assessment contains referrals for physical health services.			
	The assessment contains referrals for mental health services.			
	The assessment is reviewed and approved by a licensed physician or licensed practitioner of the healing arts.			
	The record contains documentation that the participant completed an infectious disease risk assessment, and was referred to counseling and/or testing, as appropriate.			

	There is documentation that the participant was asked about community resources (support groups, social services, other social supports) that they are currently utilizing.			
	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.			
Each treatment plan (initial and update) includes a schedule of clinical services, including individual, group, and family.			
When applicable, the treatment plan (initial and update) reflects discharge/transition planning.			
The treatment plan is reviewed and updated at regular intervals.			
Each treatment plan (initial and update) is developed with participation of the participant.			
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 review) includes documentation that the participant was offered a copy of the plan, and if they accepted or declined.			
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.			
Each treatment plan (initial and review) is signed by the alcohol and drug counselor.			

	Each treatment plan (initial and review) is reviewed and approved by a licensed physician or licensed practitioner of the healing arts.			
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.			
	All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.			
	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 clinician 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.			
	The record contains documentation that the participant received the minimum required hours for the program level of treatment they are enrolled in.			
	For SUD Residential Levels 3.3/3.5: The record contains weekly progress notes at the end of each week that service is provided, that show objective progress towards goals.			
Dosing and Drug Screening				
	For Opioid Treatment Program: The record documents the ordered dosing schedule.			
	For Opioid Treatment Program: The record documents that medications were administered/dispensed according to the licensed practitioner's medication order.			
	For Opioid Treatment Program: Was guest dosing was utilized? (If not, questions #86 and #87 are N/A).			

	For Opioid Treatment Program: The record contains the home (original OTP referral to the program in which the participant will receive guest dosing) order/referral for guest dosing.			
	For Opioid Treatment Program: The record contains the documentation of the guest dosing history and notification of any concerns, if any			
	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.			
	The record contains evidence that toxicology tests were ordered, and the results.			
	When toxicology results are positive, the record contains documentation that results were addressed by staff with the participant, and appropriate action was taken.			
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 clinician.			
	Is the participant being seen by another behavioral health provider?			
	If the participant is being seen by another behavioral health clinician, 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.			