December-18

United Healthcare Community Plan (UHCCP)

TREATMENT RECORD AUDIT TOOL

Facility Name:

Member Gender:

Member Age:

Reviewer Name:

Date of Facility Review:

	Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
General Documentation Standards				
1	Each member has a separate record.			
2	Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, date of birth, gender, relationship or legal status, and guardianship information if relevant.			
3	The member's primary language is documented in the record, and any translation needs are noted.			
4	Each page of record identifies the member.			
5	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.			
6	For members under the age of 18, guardianship information is included in the record.			

7	The record is accurate and clearly legible to someone other than the writer.			
8	There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the member and/or legal guardian.			
9	The Patient Bill of Rights is either signed or refusal is documented.			
10	There is documentation that the service provider provides education to member/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.			
11	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the member and/or family or legal guardian.			
12	The member is given information to create psychiatric advance directives or refusal documented for members over the age of 18 years of age.			
13	For individuals 0 to 18, there is evidence that services are in context of the family, and that there is evidence of ongoing communication and coordination with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.			
Initial Assessment				
14	The reasons for admission or initiation of treatment are indicated, and appropriate to the services being rendered.			
15	An initial/Annual assessment is in the record, and completed by a licensed mental health professional. If the member is a child or adolescent, the primary care giver is involved in the assessment. Any standardized assessments used in the assessment are clearly documented.			

#	Item			
16	A complete clinical case formulation is documented in the record (e.g., primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments) by a licensed mental health professional, physician, or under the direction of a licensed professional, which establishes medical necessity for treatment.			
17	Presenting problem(s) are identified and an initial primary treatment DSM diagnosis is present in the record.			
18	A behavioral health history is in the record, including any previous providers, treatment dates, treatment modality and member response (if applicable).			
19	An initial health screening, either the Healthy Living Questionnaire or the PBHCI, is included in the record. **This is a non-scored question.**			
20	A medical history and/or physical exam (appropriate to the level of care) is in the record.			
21	Was a current medical condition identified? **This is a non-scored question. (If #14 is N, then #15 and 16 are N/A)**			
22	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. **This is a non-scored question.**			
23	If a medical condition was identified, there is documentation that the member/guardian refused consent for the release of information to the treating medical clinician. **This is a non-scored question.**			
24	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			

25	A complete mental status exam is in the record, documenting the member's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.			
26	The behavioral health treatment history includes the following information: dates and providers of previous treatment, treatment modality, and therapeutic interventions and responses.			
27	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.			
28	The behavioral health treatment history includes family history information.			
29	The medical treatment history includes family history information.			
30	Current medications and dosages listed, including medications from PCP and Behavioral Health Prescriber.			
31	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.			
32	The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.			

33	The behavioral health history includes an assessment of any abuse the member has experienced or if the member has been the perpetrator of abuse.			
34	If the member was a victim of abuse or neglect, documentation of report to the appropriate protective agency and Health Standards, as applicable.			
35	The assessment documents a sexual behavior history, including any issues of sexual health.			
36	The initial history for members under the age of 21 includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), and the health of the member's mother while pregnant with member.			
37	The initial screen includes an assessment for depression.			
38	The assessment documents the spiritual variables that may impact treatment.			
39	The assessment documents the cultural variables, including but not limited to race, ethnicity, and gender identity, that may impact treatment.			
40	The assessment documents any financial concerns.			
41	The assessment documents any challenges related to transportation.			
42	An educational assessment appropriate to the age and level of care is documented.			

43	The record documents the presence or absence of relevant legal issues of the member and/or family.			
44	The record documents the assessment of the member's strengths and needs, and is included in the member's treatment plan.			
45	There is documentation that the member was asked about community resources (family, support groups, social services, school based services, other social supports) that they are currently utilizing.			
46	There is evidence that the assessment is used in developing the treatment plan and goals.			
47	The member's desired outcomes of treatment are clearly documented in the record.			
48	There is evidence of preliminary discharge planning.			
49	For members 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.			
50	For members 12 and older, the substance abuse screening includes documentation of past and present use of nicotine.			
51	If the screening indicates an **active** alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.			
52	The substance identified as being misused was alcohol. **This is a non-scored question.**			

53	The substance(s) identified as being misused were substance(s) other than alcohol. **This is a non-scored question.**			
54	The substance(s) identified as being misused were alcohol and other substance(s). **This is a non-scored question.**			

Treatment Planning

55	The treatment plan is in the record, indicates the date of the initiation of the plan, whether it is the initial or updated plan, and is signed by the member/guardian and the treating licensed clinician and any other caregivers or paraprofessionals involved in care/treatment.			
56	Member's direct participation in the development of the treatment plan is in evidence.			
57	The treatment plan is consistent with diagnosis and has objective and measurable short and long term goals.			
58	Treatment Plan is specific to member and member's diagnosis.			
59	Treatment plan goals are specific, recovery focused, measurable, attainable, realistic, and time-limited (SMART). The goals are objective and include time frames for completion.			
60	The treatment goals adequately address the member's goals, as well as social and behavioral needs.			

61	Treatment plan reflects services to be provided in the amount, type, duration, and frequency.			
62	The treatment plan has estimated time frames for goal attainment.			
63	Crisis plan specific to the member that address any risk or presence of suicidal ideation inclusive of interventions to mitigate risk and action steps to be taken if the crisis cannot be averted.			
64	There is clear evidence the member was directly involved in the development of the crisis plan.			
65	The crisis plan is updated as needed to meet the member's needs.			
66	Goals/objectives align with member identified areas for improvement/outcomes, including targeting areas of risk and need, as indicated from assessment.			
67	Cultural preferences are assessed and included in the development of treatment plans.			
68	The treatment plan is updated whenever goals are achieved or new problems are identified. Progress on all goals are included in the update.			
69	There is evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member.			

#	Criteria			
70	When applicable, the treatment record**, including the treatment plan,** reflects discharge planning.			
71	An initial treatment plan is established at each level of care with goals, treatment priorities, and milestones for progress is in the record.			
72	If the member is receiving group therapy, there is evidence of an individualized assessment, treatment planning, and progress notes in response to identified member's needs.			
73	The treatment record documents and addresses biopsychosocial needs.			
74	The treatment record indicates the member's involvement in care and service.			
75	When appropriate, the treatment record indicates the family's involvement, or other support systems, in the establishing treatment goals/objectives.			
Progress Notes				
76	All progress notes document the date of service, location of service, as well as the length of service rendered when providing a timed service.			
77	All progress notes document clearly who is in attendance during each session. (outpatient services)			

78	All progress notes include documentation of the billing code that was submitted for the session, and services documented reflect services billed.			
79	Progress notes document specifically if service was provided through Telemedicine. (outpatient services)			
80	The progress notes reflect reassessments when necessary.			
81	The progress notes document on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.			
82	The progress notes document continuous substance use assessment (if applicable).			
83	The progress notes describe/list member strengths and limitations and how those impact treatment.			
84	The progress notes describe progress or lack of progress towards treatment plan goals.			
85	The progress notes document the dates of follow up appointments.			
86	The progress notes document when the member miss appointments.			
87	The progress notes support the current level of service provided.			

88	The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated, and the outcome of the referral.			
89	The progress notes document ongoing discharge planning to alternative or appropriate levels of care.			
90	The progress notes show evidence of treatment being provided in a culturally competent manner.			
91	When appropriate there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)			
92	There is evidence of family and/or support system involvement in treatment, when appropriate.			
Medication Management				
93	There is documentation that indicates the member understands and consents to the medication used in treatment.			
94	For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.			
95	Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.			
96	If the member is on medication, there is evidence of medication monitoring in the treatment record, including compliance or non-compliance. (physicians and nurses)			

97	When lab work is ordered, there is evidence the lab results were received and reviewed by the clinician.			
98	Documentation that a query was done through the Prescription Monitoring Program (PMP) for behavioral health patients.			
99	AIMS (Abnormal Involuntary Movement Scale) performed when appropriate (e.g., member is being treated with antipsychotic medication).			
100	Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including weight, BMI, labs and chronic conditions.			
101	When the member is on medications, the prescribing clinician documents that the member was provided with education about the risks, benefits, side effects, and alternatives of each medication.			
102	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 days, document how many days after initiation the coordination took place.			
Coordination of Care				
103	There is evidence of a signed release of information, or a signed refusal, in the treatment record when there is another identified treating provider.			
104	Does the member have a medical physician (PCP)? **This is a non-scored question.**			
105	The record documents that the member was asked whether they have a PCP. **Y or N Only**			

106	If the member has a PCP there is documentation that communication/collaboration occurred.			
107	If the member has a PCP, there is documentation that the member/guardian refused consent for the release of information to the PCP.			
108	Is the member being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
109	The record documents that the member was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			
110	If the member is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
111	If the member is being seen by another behavioral health clinician, there is documentation that the member/guardian refused consent for the release of information to the behavioral health clinician.			
Discharge and Transfer				
112	Was the member transferred/discharged to another clinician or program? This is a non-scored question.			
113	If the member was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
114	If the member was transferred/discharged to another clinician or program, there is documentation that the member/guardian refused consent for release of information to the receiving clinician/program.			

115	Prompt referrals to the appropriate level of care are documented when members 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.			
116	For all discharged patients, the discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
117	For all discharged patients transitioning to a new level of care or behavioral health provider, the appointment date and time with the next provider is documented in the discharge plan. If there are barriers, this is documented in the plan.			
118	For all discharged patients with a co-morbid medical condition, the discharge plan includes the next appointment date and time with the PCP. If there are barriers, this is documented in the plan.			
119	For all discharged patients, the discharge/aftercare/safety plan describes specific follow up activities, and medication profile is included when appropriate. There is evidence that all items were reviewed with the patient at discharge.			
120	Clinical records are completed within 30 days following discharge.			
Patient Safety				
121	If the member was placed on an increased observation level due to harmful behavior, documentation of the appropriate precautions taken and monitoring occurred.			
122	If the member was placed in restraints/seclusion, there was evidence in the record of required evaluating the member every 15 minutes.			

Adverse Incidents				
123	If there is evidence of an adverse incident in the record, there is documented communication to the member's guardian.			
124	If there is evidence of an adverse incident in the record, there is documented communication to the appropriate protective agency when necessary.			
125	If there is evidence of an adverse incident in the record, there is documentation of communication to the health plan.			
Therapeutic Group Home (TGH) Services				
126	For members receiving TGH services, there is evidence the assessment is differentiated across life domains, as well as risk and protective factors, sufficiently so that a treatment plan can be tailored to the areas related.			
127	For members receiving TGH services, there is evidence in treatment planning of the use of a standardized comprehensive assessment (such as the CANS for children and adolescents).			
128	For TGH services, the strengths-based services and support plans were developed in partnership with the child/adolescent and the family when possible and developmentally appropriate.			
129	For TGH services, the plan is based on both clinical and functional assessments.			
Progress Summaries				

130	There is evidence of progress summaries in the record, completed at least every 90 days, or more frequently as needed.			
131	The progress summaries include documentation of the member's assessed needs, progress toward needs, and changes in progress or needs over the intervening time.			
132	The progress summary includes, but is not limited to: time period of the summary, activities that occurred over the period, progress toward goals, changes to treatment plan, any changes in medical condition, and is signed and dated by the rendering clinician.			
Psychiatric Residential Treatment Services (PRTF)				
133	For members treated at the PRTF level of care, the Plan of Care was developed and implemented no later than 72 hours after admission.			
134	For members in PRTF treatment, there is evidence the plan of care is evaluated at least once every 30 days.			
Restraints and Seclusion (when applicable)				
135	There is evidence in the record that alternatives/other less restrictive interventions were attempted			
136	Documentation of restraint/seclusion order.			
137	Documentation of physician notification of restraint.			

138	Documentation of member face to face assessment by a physician or physician extender (e.g., PA, NP, APRN) within one hour of restraint initiation/application. Documentation must show evidence of consultation with the physician or physician extender (e.g., PA, NP, APRN) as soon as possible after evaluation.			
139	Documentation of members' parent/guardian notification of restraint/seclusion as soon as possible of restraint occurring (children only).			