Optum

ID PHP Treatment Record Tool

DISPLAY NUMBER	AUDIT_QUESTION
	Assessment
001	Each member has a separate record.
002	Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.
003	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.
004	The member's record contains a signed admission order from a licensed physician.
005	A current DSM primary treatment diagnosis is in the record.
006	A complete clinical case formulation is documented in the record (e.g., primary diagnosis, medical conditions, psychosocial and environmental factors, and functional impairments.
007	The presenting problem and conditions are documented.
008	A behavioral health history is in the record.
009	The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.
010	The behavioral health treatment history includes family history information.
011	There is evidence of a physical exam being done within the first 24 hours after admission to a SUD or Eating Disorder PHP, and within 72 hours after admission to a MH PHP.
012	A medical history is in the record.
013	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.
014	The medical treatment history includes family history information.
015	Was a current medical condition identified? This is a non-scored question.
016	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. This is a non-scored question.
017	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.
018	A complete mental status exam is in the record, documenting the member's level of consciousness, attentiveness, appearance, behavior, speech, psychomotor activity, eye contact, mood, affect, thought process, thought content, perceptual disturbance, cognition, insight, and judgement.
019	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 and any behaviors that could be considered a danger toward self or others.

020	The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality as well as any behaviors that could be considered a danger toward self or others.
021	The behavioral health history includes an assessment of any abuse the member has experienced.
022	The behavioral health history includes an assessment of whether the member has been the perpetrator of abuse.
023	The behavioral health history includes an assessment of any trauma the member has experienced.
024	For Adolescents: The assessment documents a sexual behavior history.
025	For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, and academic), are documented.
026	For members under the age of 18, there is evidence that the Child and Adolescent Needs and Strengths (CANS) assessment was completed and/or updated and was utilized to identify the member specific functional need(s).
027	There is evidence the member's symptoms result in severe personal distress and/or significant psychosocial and environmental issues, as appropriate to the level of care.
028	There is evidence in the assessment that the member meets clinical and medical necessity criteria for Partial Hospitalization services.
029	The initial screen includes an assessment for depression.
030	For members 10 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.
031	For members 10 and older, the substance abuse screening includes documentation of past and present use of nicotine.
032	When an active substance issue is identified, the ASAM 6 Dimension Assessment and placement determination (as appropriate) is in the record and was completed by an individual specifically trained to complete this assessment.
033	If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.
034	The substance identified as being misused was alcohol. This is a non-scored question.
035	The substance(s) identified as being misused were substance(s) other than alcohol. This is a non-scored question.
036	The substances identified as being misused were alcohol and other substance(s). This is a non-scored question.
037	The assessment documents the spiritual variables that may impact treatment.
038	The assessment documents the cultural variables that may impact treatment.
039	The record contains an initial treatment plan with goals, treatment priorities, and milestones for progress that would be reasonably achievable within the PHP standard treatment window of 3-6 weeks.
040	An educational assessment appropriate to the member's age is documented.

041	The record documents the presence or absence of relevant legal issues of the member and/or family.
042	There is documentation that the member was asked about community resources (support groups, social services, school-based services, other social supports) that they are currently utilizing.
043	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.
044	The member's complete medication reconciliation is documented in the record including dose, frequency, and start date of current psychiatric medications and the start and stop date of any psychiatric medications discontinued within at least the past twelve (12) months.
045	The clinician uses a Consent for Treatment or Informed Consent form with all members; this document should be signed by the member and/or legal guardian.
046	There is evidence that the assessment is used in developing the treatment plan and goals.
047	On an annual basis, the member is reassessed. This includes the member's current status and a new mental status exam.
048	The documentation in the treatment record includes the onset, duration, frequency, and severity of the symptoms the member is experiencing.
049	The documentation in the treatment record identifies functional needs the member is experiencing, and how they will be addressed in the treatment services.
050	There is evidence of Medical Director or designee involvement in the member's assessment and reassessment. (May be marked N/A in IOP)
	Coordination of Care
051	The name of the member's primary care physician (PCP) documented in the record (All members should have a PCP; if not, they should be referred to a PCP.)
052	The record documents that the member was asked whether they have a PCP. Y or N Only
053	If the member has a PCP there is documentation that communication/collaboration occurred.
054	If the member has a PCP, there is documentation that the member/guardian refused consent for the release of information to the PCP
055	Is the member being seen by another behavioral health clinician (e.g., psychiatrist, social worker, psychologist, and/or substance abuse counselor) and/or were they seen by another behavioral health clinician in the past? This is a non-scored question.
056	The record documents that the member was asked whether they are being seen by another behavioral health practitioner.
057	If the member has another behavioral health practitioner there is documentation that communication/collaboration occurred.
058	If the member has another behavioral health practitioner, there is documentation that the member/guardian refused consent for the release of information to the other behavioral health clinician.
059	For members who are receiving a behavioral health or substance use disorder service at another agency, there is evidence in the record of active case consulting with the other service provider.

	Person-Centered Care
060	A specific service plan is in place that is geared towards the individual member's needs and strengths.
061	The treatment plan includes treatment goals in the member's own words
062	The treatment plan includes the anticipated program discharge date.
	Documentation Related to the Treatment Plan
063	There is documentation (a signed form or in progress note) that the member or legal guardian (based on each state's age of consent) has agreed to the treatment plan.
064	The treatment plan is consistent with the diagnosis.
065	For members 18 years of age and under, there is evidence that the results of the CANS were used in developing the treatment plan.
066	The treatment plan has short term measurable goals achievable within a 3–6-week treatment window.
067	The treatment plan has long term goals (including long term goals that follow successful discharge from the PHP program).
068	The treatment plan includes the identified interventions, including who is responsible.
069	The treatment plan includes a safety plan when active risk issues are identified.
070	The treatment plan has measurable objectives.
071	The treatment plan has estimated time frames for goal attainment.
072	The identified interventions in the treatment plan are appropriate for the member based on their individual needs and strengths.
073	The treatment plan is updated whenever goals are achieved, or new problems are identified.
074	The treatment plan is reviewed and updated with the patient at least every fourteen (14) days.
075	The treatment record, including the treatment plan, reflects discharge planning.
076	If a member is receiving services in a group setting, there is evidence of an individualized assessment, treatment planning, and progress notes in response to identified member needs.
077	The treatment record documents and addresses biopsychosocial needs.
078	The treatment record is signed by the treatment team and the member, and a copy of the treatment plan was offered to the member.
079	When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.
080	There is evidence of Medical Director or designee involvement in member's treatment including updates to treatment plans. (May be marked N/A in IOP)
081	There is evidence of Registered nurse or higher that is available 24 hours as part of program
082	There is evidence that the member has been notified of services that must be received within the PHP program.
083	There is evidence that the member received required services, or documentation of why not.
	Progress Notes

084	All progress notes document the start and stop times for each session.
085	All progress notes document clearly who is in attendance during each session.
086	All progress notes include documentation of the billing code, or the specific service, which was provided.
087	The progress note indicates the type of intervention that was used for the session.
088	The progress notes reflect reassessments when necessary.
089	The progress notes reflect on-going risk assessments (including but not limited to suicide, homicide, and dangerous behaviors) and monitoring of any at risk situations.
090	The progress notes describe progress or lack of progress towards treatment plan goals.
091	The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.
092	The progress notes document the use of any preventive services (relapse prevention, stress management, wellness programs and referrals to community resources).
093	There is evidence of documentation for weekly medical visits with the program medical director or designee. There is evidence that medication was discussed.
094	For members in SUD PHP, there is documented evidence that Medication Assisted Treatment (MAT) was offered and if declined, as applicable.
095	When a primary care physician is identified, there is evidence the prescriber coordinated care within 14 calendar days after initiation of a new medication.
096	There is documentation that indicates the member understands and consents to the medication used in treatment.
097	For children and adolescents' documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.
098	Each record indicates what medications have been prescribed, the dosages of each, and the start and stop dates.
099	When lab work is ordered, there is evidence the lab results were received and reviewed by the medical provider, including the provider's initials and date reviewed.
100	When lab work is ordered, there is evidence that the medical provider reviewed the results with the member.
101	The progress notes document the dates of follow up appointments.
102	The progress notes document when members miss appointments.
103	When a member misses an appointment, there is documentation of outreach efforts (phone calls, missed appointment letters) the provider makes to reengage the member in treatment and communicate minimal attendance expectations for PHP level of care.
104	There is evidence of Family Therapy treatment or that the service was offered and declined, as applicable.
105	There is evidence of Individual Therapy treatment or that the service was offered and declined, as applicable.
	Transition of Care
106	Was the member transferred/discharged to another clinician or program? This is a non-scored question.

107	If the member was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.
108	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.
109	The reason for discharge is clearly identified.
110	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.
111	The discharge/aftercare plan describes specific follow up activities including appointment times for follow up appointments and evidence that a copy of the discharge plan was given to member.
112	Treatment records are completed within 30 days following discharge.
113	When appropriate there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)
	Treatment Staffing
114	The record includes evidence that the medical director attended at least 2 staffing meetings per month
115	There is evidence in the record that staffing meetings occurred weekly for each member admitted to the PHP.
116	Staffing meetings are documented, including a list of members staffed, and treatment team members in attendance.
	Education
117	There is documentation that the provider offers education to members/families about care options, participation in care and coping with behavioral health problems.
118	There is documentation that the provider offers education to members/families about prognosis and outcomes.
119	There is documentation that the risks of not participating in treatment are discussed with the member.
	ALERT
120	FOR OUTPATIENT SERVICES ONLY: There is a completed wellness assessment (or documentation that the member refused to complete a wellness assessment) in the record.
	Interpreter Services
121	If the member has limited English proficiency, there is documentation that interpreter services were offered, and whether the services were accepted or declined.
	Recovery and Resiliency
122	The member is given information to create psychiatric advance directives when appropriate. This is a non-scored question.