Optum

Audit Findings Summary - 3rd and 4th Quarter 2022

This *Audit Findings Summary* reflects findings for two hundred (200) total Provider audits, conducted in the 3rd and 4th Quarters of 2022.

The summary reflects audit data, in terms of averages by both scored quality line item and overall average by Provider. Non-scored and quality line items scoring N/A are not included in the data.

A Program Improvement Plan (PIP) was required of a Provider for any section(s) of quality line items that resulted in an average score of less than 85%, calculated across total records reviewed in an audit.

Certain audit findings result in the recommended recovery of funds and/or referral to the Office of Inspector General (OIG).

Individual Provider: PhD/PsyD	
Quality Line Item	**Average Score**
Each participant has a separate record.	92%
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.	64%
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.	77%
The record is clearly legible to someone other than the writer.	74%
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.	60%
The record contains legal documentation to verify that the consent was given by the appropriate person.	44%
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.	42%
The record contains documentation that the provider informed the participant of the purpose and nature of an evaluation or treatment process.	53%
The record contains documentation that the provider informed the participant of the additional options to the proposed treatment.	34%
The record contains documentation that the provider informed the participant of the potential reactions to the proposed treatment.	39%
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.	31%
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.	26%
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.	0%
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.	0%
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.	15%
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.	11%
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.	27%
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).	18%
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.	0%
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.	20%
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.	0%
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.	0%
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.	0%
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.	0%

For psychologists: The record documents the participant's original test data with results and other evaluative material.	65%
For psychologists: The record documents the results of any formal consultations with other professionals.	30%
The record contains an individualized assessment, completed by the provider.	80%
The assessment includes the participant or family's presenting problem.	78%
The assessment includes the participant or family's history.	75%
The assessment includes the diagnosis, based on DSM-V.	65%
The assessment includes a rationale for the diagnosis.	64%
The assessment contains a complete mental status exam.	50%
The record contains documentation of the participant's medical history.	57%
The medical history includes family history information.	25%
The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.	17%
The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	55%
The behavioral health treatment history includes family history information.	44%
The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.	42%
The medical treatment history includes family history information.	18%
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.	58%
The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	48%
For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.	9%
For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.	52%
The assessment includes an assessment for depression.	48%
The assessment documents the spiritual variables that may impact treatment.	15%
The assessment documents the cultural variables that may impact treatment.	13%
An educational assessment appropriate to the age and level of care is documented.	65%
The record documents the presence or absence of relevant legal issues of the participant and/or family.	47%
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.	26%
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.	50%
For participant 12 and older, the substance use screening includes documentation of past and present use of nicotine.	23%

If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.	16%
The record contains reassessments, when necessary.	39%
An initial treatment plan is established at each level of care.	36%
Each treatment plan (initial and update) is individualized.	35%
There is evidence that the assessment is used in developing the treatment plan and goals.	30%
Each treatment plan (initial and update) states the participant's problems.	28%
Each treatment plan (initial and update) states the participant's needs.	15%
Each treatment plan (initial and update) states the participant's strengths.	15%
Each treatment plan (initial and update) has objective and measurable short and long term goals.	8%
Each treatment plan (initial and update) includes estimated time frames for goal attainment.	21%
Each treatment plan (initial and update) includes medically necessary interventions.	15%
When applicable, the treatment plan reflects discharge planning.	5%
The record indicates the participant's involvement in treatment planning.	21%
When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.	21%
The treatment plan is reviewed and updated with the participant or parent/legal guardian (if applicable) at regular intervals.	18%
The treatment plan is updated whenever goals are achieved or new problems are identified.	18%
Each treatment plan review documents progress towards goals.	21%
The record includes a safety plan, completed with the participant, when active risk issues are identified.	4%
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.	16%
Each treatment plan (initial and reviews) are signed by the provider.	31%
All progress/contact notes document the start time and end time the service was rendered.	68%
All progress/contact notes document the location where service was rendered.	52%
All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.	55%
All progress/contact notes document clearly who is in attendance during each session.	55%
All progress/contact notes document the participant's mental status.	36%
All progress/contact notes contain a summary of interventions.	44%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	40%

The progress/contact notes describe progress or lack of progress towards treatment plan goals.	13%
The progress/contact notes reflect reassessments, when necessary.	37%
The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).	48%
The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.	25%
The progress/contact notes document the dates of follow-up appointments.	20%
The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.	42%
If the participant has a PCP, there is documentation that communication/collaboration occurred.	21%
If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.	17%
If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.	5%
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.	15%
For all discharged participants, the discharge summary documentation is comprehensive.	21%
For all discharged participants, the discharge plan describes specific follow-up activities.	13%
Clinical records are completed within 30 days following discharge.	35%
Overall Average	39%

Individual Provider: LCPC, LCMFT, LCADC, LCPAT	
Quality Line Item	**Average Score**
Each participant has a separate record.	74%
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.	58%
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.	63%
The record is clearly legible to someone other than the writer.	75%
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.	55%
The record contains legal documentation to verify that the consent was given by the appropriate person.	41%
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.	44%
The record contains documentation that the provider informed the participant of the purpose and nature of an evaluation or treatment process.	48%
The record contains documentation that the provider informed the participant of the additional options to the proposed treatment.	39%
The record contains documentation that the provider informed the participant of the potential reactions to the proposed treatment.	43%
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.	37%
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.	22%
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.	7%
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.	0%
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.	29%
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.	0%
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.	28%
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).	30%
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.	27%
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.	10%
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.	0%
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.	0%
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.	0%
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.	0%

The record contains an individualized assessment, completed by the provider.	63%
The assessment includes the participant or family's presenting problem.	62%
The assessment includes the participant or family's history.	59%
The assessment includes the diagnosis, based on DSM-V.	58%
The assessment includes a rationale for the diagnosis.	56%
The assessment contains a complete mental status exam.	52%
The record contains documentation of the participant's medical history.	53%
The medical history includes family history information.	22%
The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.	30%
The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	52%
The behavioral health treatment history includes family history information.	43%
The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.	40%
The medical treatment history includes family history information.	18%
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.	57%
The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	48%
For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.	18%
For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.	27%
The assessment includes an assessment for depression.	36%
The assessment documents the spiritual variables that may impact treatment.	31%
The assessment documents the cultural variables that may impact treatment.	23%
An educational assessment appropriate to the age and level of care is documented.	56%
The record documents the presence or absence of relevant legal issues of the participant and/or family.	53%
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.	31%
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.	59%
For participant 12 and older, the substance use screening includes documentation of past and present use of nicotine.	23%
If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.	33%
The record contains reassessments, when necessary.	34%

An initial treatment plan is established at each level of care.	59%
Each treatment plan (initial and update) is individualized.	56%
There is evidence that the assessment is used in developing the treatment plan and goals.	55%
Each treatment plan (initial and update) states the participant's problems.	53%
Each treatment plan (initial and update) states the participant's needs.	26%
Each treatment plan (initial and update) states the participant's strengths.	29%
Each treatment plan (initial and update) has objective and measurable short and long term goals.	30%
Each treatment plan (initial and update) includes estimated time frames for goal attainment.	42%
Each treatment plan (initial and update) includes medically necessary interventions.	48%
When applicable, the treatment plan reflects discharge planning.	23%
The record indicates the participant's involvement in treatment planning.	44%
When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.	30%
The treatment plan is reviewed and updated with the participant or parent/legal guardian (if applicable) at regular intervals.	36%
The treatment plan is updated whenever goals are achieved or new problems are identified.	34%
Each treatment plan review documents progress towards goals.	30%
The record includes a safety plan, completed with the participant, when active risk issues are identified.	13%
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.	26%
Each treatment plan (initial and reviews) are signed by the provider.	51%
All progress/contact notes document the start time and end time the service was rendered.	57%
All progress/contact notes document the location where service was rendered.	45%
All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.	60%
All progress/contact notes document clearly who is in attendance during each session.	63%
All progress/contact notes document the participant's mental status.	47%
All progress/contact notes contain a summary of interventions.	53%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	25%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	38%
The progress/contact notes reflect reassessments, when necessary.	31%

The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).	47%
The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.	6%
The progress/contact notes document the dates of follow-up appointments.	37%
The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.	33%
If the participant has a PCP, there is documentation that communication/collaboration occurred.	16%
If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.	30%
If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.	6%
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.	11%
For all discharged participants, the discharge summary documentation is comprehensive.	25%
For all discharged participants, the discharge plan describes specific follow-up activities.	20%
Clinical records are completed within 30 days following discharge.	42%
Overall Average	43%

Individual Provider: LCSW-C	
Quality Line Item	**Average Score**
Each participant has a separate record.	75%
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.	57%
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.	62%
The record is clearly legible to someone other than the writer.	75%
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.	66%
The record contains legal documentation to verify that the consent was given by the appropriate person.	31%
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.	48%
The record contains documentation that the provider informed the participant of the purpose and nature of an evaluation or treatment process.	57%
The record contains documentation that the provider informed the participant of the additional options to the proposed treatment.	45%
The record contains documentation that the provider informed the participant of the potential reactions to the proposed treatment.	48%
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.	43%
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.	32%
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.	0%
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.	10%
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.	23%
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.	0%
The record contains an individualized assessment, completed by the provider.	64%
The assessment includes the participant or family's presenting problem.	63%
The assessment includes the participant or family's history.	63%
The assessment includes the diagnosis, based on DSM-V.	54%
The assessment includes a rationale for the diagnosis.	53%
The assessment contains a complete mental status exam.	44%
The record contains documentation of the participant's medical history.	57%
The medical history includes family history information.	15%

The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.	41%
The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	54%
The behavioral health treatment history includes family history information.	39%
The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.	54%
The medical treatment history includes family history information.	13%
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.	48%
The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	40%
For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.	10%
For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.	49%
The assessment includes an assessment for depression.	38%
The assessment documents the spiritual variables that may impact treatment.	34%
The assessment documents the cultural variables that may impact treatment.	27%
An educational assessment appropriate to the age and level of care is documented.	58%
The record documents the presence or absence of relevant legal issues of the participant and/or family.	47%
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.	34%
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.	53%
For participant 12 and older, the substance use screening includes documentation of past and present use of nicotine.	37%
If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.	19%
The record contains reassessments, when necessary.	37%
An initial treatment plan is established at each level of care.	63%
Each treatment plan (initial and update) is individualized.	62%
There is evidence that the assessment is used in developing the treatment plan and goals.	54%
Each treatment plan (initial and update) states the participant's problems.	63%
Each treatment plan (initial and update) states the participant's needs.	30%
Each treatment plan (initial and update) states the participant's strengths.	43%
Each treatment plan (initial and update) has objective and measurable short and long term goals.	26%
Each treatment plan (initial and update) includes estimated time frames for goal attainment.	39%

Each treatment plan (initial and update) includes medically necessary interventions.	41%
When applicable, the treatment plan reflects discharge planning.	26%
The record indicates the participant's involvement in treatment planning.	47%
When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.	29%
The treatment plan is reviewed and updated with the participant or parent/legal guardian (if applicable) at regular intervals.	34%
The treatment plan is updated whenever goals are achieved or new problems are identified.	31%
Each treatment plan review documents progress towards goals.	30%
The record includes a safety plan, completed with the participant, when active risk issues are identified.	19%
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.	45%
Each treatment plan (initial and reviews) are signed by the provider.	55%
All progress/contact notes document the start time and end time the service was rendered.	63%
All progress/contact notes document the location where service was rendered.	48%
All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.	71%
All progress/contact notes document clearly who is in attendance during each session.	59%
All progress/contact notes document the participant's mental status.	48%
All progress/contact notes contain a summary of interventions.	49%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	23%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	30%
The progress/contact notes reflect reassessments, when necessary.	43%
The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).	55%
The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.	15%
The progress/contact notes document the dates of follow-up appointments.	39%
The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.	34%
If the participant has a PCP, there is documentation that communication/collaboration occurred.	22%
If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.	13%
If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.	6%
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.	8%

For all discharged participants, the discharge summary documentation is comprehensive.	14%
For all discharged participants, the discharge plan describes specific follow-up activities.	15%
Clinical records are completed within 30 days following discharge.	16%
Overall Average	44%

Outpatient Mental Health Center (OMHC)	
Quality Line Item	**Average Score**
Each participant has a separate record.	99%
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.	84%
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.	93%
The record is clearly legible to someone other than the writer.	97%
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.	69%
The record contains legal documentation to verify that the consent was given by the appropriate person.	71%
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.	56%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	49%
The record contains documentation of entitlements that the participant receives, including amounts.	1%
The record contains documentation that the participant or parent/legal guardian applied for the entitlements for which the participant may be eligible, and the outcome.	5%
The record contains documentation of how the program assisted the participant or parent/legal guardian in applying for entitlements, if the application was not already submitted.	2%
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.	43%
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.	82%
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.	93%
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.	67%
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.	25%
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.	40%
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.	20%
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).	20%
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.	20%
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.	9%
The record contains an individualized assessment.	87%
The assessment includes the participant or family's presenting problem.	86%
The assessment includes the participant or family's history.	87%

The assessment includes the diagnosis, based on DSM-V.	87%
The assessment includes a rationale for the diagnosis.	85%
The assessment contains a complete mental status exam.	81%
The record contains documentation of the participant's medical history.	86%
The medical history includes family history information.	50%
The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.	73%
The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	81%
The behavioral health treatment history includes family history information.	79%
The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.	78%
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.	86%
The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	78%
For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.	36%
For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.	80%
The assessment includes an assessment for depression.	61%
The assessment documents the spiritual variables that may impact treatment.	32%
The assessment documents the cultural variables that may impact treatment.	34%
An educational assessment appropriate to the age and level of care is documented.	82%
The record documents the presence or absence of relevant legal issues of the participant and/or family.	77%
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.	52%
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.	81%
For participant 12 and older, the substance use screening includes documentation of past and present use of nicotine.	61%
If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.	45%
The record contains reassessments, when necessary.	68%
An initial treatment plan is established at each level of care.	84%
Each treatment plan (initial and update) is individualized.	86%
There is evidence that the assessment is used in developing the treatment plan and goals.	82%
Each treatment plan (initial and update) states the participant's problems.	82%

Each treatment plan (initial and update) states the participant's needs.	78%
Each treatment plan (initial and update) states the participant's strengths.	82%
Each treatment plan (initial and update) has objective and measurable short and long term goals.	53%
Each treatment plan (initial and update) includes estimated time frames for goal attainment.	80%
Each treatment plan (initial and update) includes medically necessary interventions.	70%
When applicable, the treatment plan (initial and update) reflects discharge/transition planning.	63%
The record indicates the participant's involvement in treatment planning.	76%
When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.	56%
The treatment plan is reviewed and updated with the participant or parent/legal guardian (if applicable) at regular intervals.	75%
The treatment plan is updated whenever goals are achieved or new problems are identified.	73%
Each treatment plan review documents progress towards goals.	55%
The record includes a safety plan, completed with the participant, when active risk issues are identified.	67%
Each treatment plan (initial and reviews) includes documentation that the participant or parent/legal guardian was offered a copy of the plan and if they accepted or declined.	57%
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.	61%
Each treatment plan (initial and reviews) are signed by the provider.	77%
For OMHC: In addition to participant or parent/legal guardian signatures, each treatment plan (initial and reviews) is also signed by at least two mental health professionals who collaborate on the participant's treatment and, if medications are prescribed through the OMHC, the prescriber.	41%
All progress/contact notes document the start time and end time the service was rendered.	97%
All progress/contact notes document the location where service was rendered.	87%
All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.	92%
All progress/contact notes document clearly who is in attendance during each session.	97%
All progress/contact notes document the participant's mental status.	70%
All progress/contact notes contain a summary of interventions.	91%
All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.	98%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	86%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	67%
The progress/contact notes reflect reassessments, when necessary.	82%
The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).	82%

The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.	71%
The progress/contact notes document the dates of follow-up appointments.	55%
The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.	91%
Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.	96%
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.	10%
If the participant is on medication, there is evidence of medication monitoring in the treatment record.	98%
When lab work is ordered, there is evidence the lab results were received and reviewed by the prescribing provider.	89%
If the participant has a PCP, there is documentation that communication/collaboration occurred.	27%
If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.	46%
If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.	13%
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.	0%
For all discharged participants, the discharge summary documentation is comprehensive.	79%
For all discharged participants, the discharge plan describes specific follow-up activities.	51%
Clinical records are completed within 30 days following discharge.	92%
Overall Average	71%

SUD Level 1 Outpatient Program (SUD OP)	
Quality Line Item	**Average Score**
Each participant has a separate record.	98%
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.	92%
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.	86%
The record is clearly legible to someone other than the writer.	95%
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.	78%
The record contains legal documentation to verify that the consent was given by the appropriate person.	63%
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.	54%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	35%
The record contains documentation that the participant received infectious health education.	59%
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.	45%
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.	78%
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.	75%
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.	0%
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.	41%
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.	36%
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.	26%
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).	26%
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.	17%
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.	1%
The record contains an individualized assessment.	88%
The assessment includes the participant's presenting problem.	85%
The assessment contains a comprehensive history.	82%
The assessment includes the diagnosis, based on DSM-V.	74%
The assessment contains a complete mental status exam.	66%

The record contains documentation of the participant's medical history.	82%
The medical history includes family history information.	31%
The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.	55%
The record contains documentation of the participant's behavioral health treatment history.	78%
The behavioral health treatment history includes family history information.	51%
The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.	63%
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.	83%
The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	78%
The assessment documents the spiritual variables that may impact treatment.	39%
The assessment documents the cultural variables that may impact treatment.	35%
The assessment documents a recommendation for appropriate level of substance use disorder treatment.	65%
The participant meets ASAM criteria for the recommended level of substance use disorder treatment.	52%
The participant is enrolled in the recommended level of substance use treatment.	68%
The assessment contains referrals for physical health services.	17%
The assessment contains referrals for mental health services.	38%
The assessment is reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	67%
The record contains documentation that the participant completed an infectious disease risk assessment, and was referred to counseling and/or testing, as appropriate.	70%
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.	44%
The record contains reassessments, when necessary.	9%
An initial treatment plan is established at each level of care.	80%
Each treatment plan (initial and update) is individualized.	78%
There is evidence that the assessment is used in developing the treatment plan and goals.	80%
Each treatment plan (initial and update) states the participant's problems.	77%
Each treatment plan (initial and update) states the participant's needs.	55%
Each treatment plan (initial and update) states the participant's strengths.	58%
Each treatment plan (initial and update) has objective and measurable short and long term goals.	32%
Each treatment plan (initial and update) includes estimated time frames for goal attainment.	73%

Each treatment plan (initial and update) includes medically necessary interventions.	71%
Each treatment plan (initial and update) includes a schedule of clinical services, including individual, group, and family.	57%
When applicable, the treatment plan (initial and update) reflects discharge/transition planning.	42%
The treatment plan is reviewed and updated at regular intervals.	66%
Each treatment plan (initial and update) is developed with participation of the participant.	69%
Each treatment plan review documents progress towards goals.	37%
The record includes a safety plan, completed with the participant, when active risk issues are identified.	38%
Each treatment plan (initial and reviews) includes documentation that the participant or parent/legal guardian was offered a copy of the plan and if they accepted or declined.	14%
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.	71%
Each treatment plan (initial and review) is signed by the alcohol and drug counselor.	78%
Each treatment plan (initial and review) is reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	61%
All progress/contact notes document the start time and end time the service was rendered.	75%
All progress/contact notes document the location where service was rendered.	57%
All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.	83%
All progress/contact notes document clearly who is in attendance during each session.	91%
All progress/contact notes document the participant's mental status.	41%
All progress/contact notes contain a summary of interventions.	91%
All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.	88%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	48%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	42%
The progress/contact notes reflect reassessments, when necessary.	47%
The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).	49%
The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.	29%
The progress/contact notes document the dates of follow-up appointments.	15%
The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.	63%
The record contains documentation that the participant received the minimum required hours for the program level of treatment they are enrolled in.	60%
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.	75%

If the participant is on medication, there is evidence of medication monitoring in the treatment record.	80%
The record contains evidence that toxicology tests were ordered, and the results.	54%
When toxicology results are positive, the record contains documentation that results were addressed by staff with the participant, and appropriate action was taken.	43%
If the participant has a PCP, there is documentation that communication/collaboration occurred.	28%
If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.	31%
If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.	67%
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.	20%
For all discharged participants, the discharge summary documentation is comprehensive.	69%
For all discharged participants, the discharge plan describes specific follow-up activities.	62%
Clinical records are completed within 30 days following discharge.	77%
Overall Average	63%

SUD Level 2.1 Intensive Outpatient Program (SUD IOP)	
Quality Line Item	**Average Score**
Each participant has a separate record.	95%
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.	87%
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.	86%
The record is clearly legible to someone other than the writer.	91%
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.	80%
The record contains legal documentation to verify that the consent was given by the appropriate person.	70%
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.	60%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	41%
The record contains documentation that the participant received infectious health education.	61%
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.	50%
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.	50%
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.	74%
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.	38%
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.	18%
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.	53%
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).	53%
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.	46%
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.	0%
The record contains an individualized assessment.	85%
The assessment includes the participant's presenting problem.	81%
The assessment contains a comprehensive history.	78%
The assessment includes the diagnosis, based on DSM-V.	69%
The assessment contains a complete mental status exam.	56%
The record contains documentation of the participant's medical history.	77%

The medical history includes family history information.	34%
The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.	59%
The record contains documentation of the participant's behavioral health treatment history.	79%
The behavioral health treatment history includes family history information.	59%
The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.	69%
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.	82%
The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	76%
The assessment documents the spiritual variables that may impact treatment.	33%
The assessment documents the cultural variables that may impact treatment.	28%
The assessment documents a recommendation for appropriate level of substance use disorder treatment.	72%
The participant meets ASAM criteria for the recommended level of substance use disorder treatment.	48%
The participant is enrolled in the recommended level of substance use treatment.	66%
The assessment contains referrals for physical health services.	14%
The assessment contains referrals for mental health services.	36%
The assessment is reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	64%
The record contains documentation that the participant completed an infectious disease risk assessment, and was referred to counseling and/or testing, as appropriate.	65%
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.	47%
The record contains reassessments, when necessary.	14%
An initial treatment plan is established at each level of care.	81%
Each treatment plan (initial and update) is individualized.	80%
There is evidence that the assessment is used in developing the treatment plan and goals.	81%
Each treatment plan (initial and update) states the participant's problems.	78%
Each treatment plan (initial and update) states the participant's needs.	52%
Each treatment plan (initial and update) states the participant's strengths.	57%
Each treatment plan (initial and update) has objective and measurable short and long term goals.	31%
Each treatment plan (initial and update) includes estimated time frames for goal attainment.	68%
Each treatment plan (initial and update) includes medically necessary interventions.	70%

Each treatment plan (initial and update) includes a schedule of clinical services, including individual, group, and family.	55%
When applicable, the treatment plan (initial and update) reflects discharge/transition planning.	31%
The treatment plan is reviewed and updated at regular intervals.	61%
Each treatment plan (initial and update) is developed with participation of the participant.	69%
Each treatment plan review documents progress towards goals.	38%
The record includes a safety plan, completed with the participant, when active risk issues are identified.	30%
Each treatment plan (initial and reviews) includes documentation that the participant or parent/legal guardian was offered a copy of the plan and if they accepted or declined.	15%
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.	69%
Each treatment plan (initial and review) is signed by the alcohol and drug counselor.	75%
Each treatment plan (initial and review) is reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	63%
All progress/contact notes document the start time and end time the service was rendered.	74%
All progress/contact notes document the location where service was rendered.	61%
All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.	84%
All progress/contact notes document clearly who is in attendance during each session.	91%
All progress/contact notes document the participant's mental status.	37%
All progress/contact notes contain a summary of interventions.	88%
All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.	89%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	52%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	50%
The progress/contact notes reflect reassessments, when necessary.	40%
The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).	35%
The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.	28%
The progress/contact notes document the dates of follow-up appointments.	16%
The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.	66%
The record contains documentation that the participant received the minimum required hours for the program level of treatment they are enrolled in.	72%
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.	92%
If the participant is on medication, there is evidence of medication monitoring in the treatment record.	89%

The record contains evidence that toxicology tests were ordered, and the results.	58%
When toxicology results are positive, the record contains documentation that results were addressed by staff with the participant, and appropriate action was taken.	46%
If the participant has a PCP, there is documentation that communication/collaboration occurred.	27%
If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.	30%
If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.	53%
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.	12%
For all discharged participants, the discharge summary documentation is comprehensive.	57%
For all discharged participants, the discharge plan describes specific follow-up activities.	54%
Clinical records are completed within 30 days following discharge.	64%
Overall Average	62%

SUD Residential Level 3.1 Program	
Quality Line Item	**Average Score**
Each participant has a separate record.	90%
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.	90%
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.	90%
The record is clearly legible to someone other than the writer.	90%
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.	0%
The record contains legal documentation to verify that the consent was given by the appropriate person.	0%
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.	0%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	0%
The record contains documentation that the participant received infectious health education.	0%
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.	0%
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.	0%
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.	90%
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.	0%
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.	0%
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.	0%
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).	0%
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.	0%
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.	0%
The record contains an individualized assessment.	20%
The assessment includes the participant's presenting problem.	20%
The assessment contains a comprehensive history.	10%
The assessment includes the diagnosis, based on DSM-V.	20%
The assessment contains a complete mental status exam.	10%
The record contains documentation of the participant's medical history.	10%

The medical history includes family history information.	0%
The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.	0%
The record contains documentation of the participant's behavioral health treatment history.	0%
The behavioral health treatment history includes family history information.	0%
The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.	0%
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.	10%
The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	0%
The assessment documents the spiritual variables that may impact treatment.	0%
The assessment documents the cultural variables that may impact treatment.	0%
The assessment documents a recommendation for appropriate level of substance use disorder treatment.	10%
The participant meets ASAM criteria for the recommended level of substance use disorder treatment.	10%
The participant is enrolled in the recommended level of substance use treatment.	10%
The assessment contains referrals for physical health services.	0%
The assessment contains referrals for mental health services.	0%
The assessment is reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	10%
The record contains documentation that the participant completed an infectious disease risk assessment, and was referred to counseling and/or testing, as appropriate.	0%
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.	0%
The record contains reassessments, when necessary.	0%
An initial treatment plan is established at each level of care.	10%
Each treatment plan (initial and update) is individualized.	10%
There is evidence that the assessment is used in developing the treatment plan and goals.	10%
Each treatment plan (initial and update) states the participant's problems.	10%
Each treatment plan (initial and update) states the participant's needs.	10%
Each treatment plan (initial and update) states the participant's strengths.	10%
Each treatment plan (initial and update) has objective and measurable short and long term goals.	0%
Each treatment plan (initial and update) includes estimated time frames for goal attainment.	10%
Each treatment plan (initial and update) includes medically necessary interventions.	0%

Each treatment plan (initial and update) includes a schedule of clinical services, including individual, group, and family.	0%
When applicable, the treatment plan (initial and update) reflects discharge/transition planning.	0%
The treatment plan is reviewed and updated at regular intervals.	30%
Each treatment plan (initial and update) is developed with participation of the participant.	10%
Each treatment plan review documents progress towards goals.	0%
The record includes a safety plan, completed with the participant, when active risk issues are identified.	0%
Each treatment plan (initial and reviews) includes documentation that the participant or parent/legal guardian was offered a copy of the plan and if they accepted or declined.	0%
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.	20%
Each treatment plan (initial and review) is signed by the alcohol and drug counselor.	30%
Each treatment plan (initial and review) is reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	0%
All progress/contact notes document the start time and end time the service was rendered.	20%
All progress/contact notes document the location where service was rendered.	10%
All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.	90%
All progress/contact notes document clearly who is in attendance during each session.	80%
All progress/contact notes document the participant's mental status.	50%
All progress/contact notes contain a summary of interventions.	30%
All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.	10%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	0%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	0%
The progress/contact notes reflect reassessments, when necessary.	0%
The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).	80%
The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.	0%
The progress/contact notes document the dates of follow-up appointments.	0%
The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.	0%
The record contains documentation that the participant received the minimum required hours for the program level of treatment they are enrolled in.	10%
The record contains evidence that toxicology tests were ordered, and the results.	0%
When toxicology results are positive, the record contains documentation that results were addressed by staff with the participant, and appropriate action was taken.	0%

If the participant has a PCP, there is documentation that communication/collaboration occurred.	0%
If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.	89%
If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.	0%
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.	0%
For all discharged participants, the discharge summary documentation is comprehensive.	67%
For all discharged participants, the discharge plan describes specific follow-up activities.	50%
Clinical records are completed within 30 days following discharge.	67%
Overall Average	17%

Opioid Treatment Service (OTS)	
Quality Line Item	**Average Score**
Each participant has a separate record.	75%
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.	75%
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.	75%
The record is clearly legible to someone other than the writer.	75%
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.	75%
The record contains legal documentation to verify that the consent was given by the appropriate person.	50%
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.	75%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	63%
The record contains documentation that the participant received infectious health education.	75%
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.	65%
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.	67%
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.	75%
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.	29%
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.	41%
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.	0%
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).	0%
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.	0%
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.	0%
The record contains an individualized assessment.	63%
The assessment includes the participant's presenting problem.	63%
The assessment contains a comprehensive history.	63%
The assessment includes the diagnosis, based on DSM-V.	63%
The assessment contains a complete mental status exam.	63%
The record contains documentation of the participant's medical history.	63%

The medical history includes family history information.	50%
The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.	63%
The record contains documentation of the participant's behavioral health treatment history.	63%
The behavioral health treatment history includes family history information.	63%
The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.	63%
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.	63%
The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	63%
The assessment documents the spiritual variables that may impact treatment.	13%
The assessment documents the cultural variables that may impact treatment.	13%
The assessment documents a recommendation for appropriate level of substance use disorder treatment.	63%
The participant meets ASAM criteria for the recommended level of substance use disorder treatment.	63%
The participant is enrolled in the recommended level of substance use treatment.	63%
The assessment contains referrals for physical health services.	0%
The assessment contains referrals for mental health services.	12%
The assessment is reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	63%
The record contains documentation that the participant completed an infectious disease risk assessment, and was referred to counseling and/or testing, as appropriate.	63%
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.	63%
The record contains reassessments, when necessary.	58%
An initial treatment plan is established at each level of care.	75%
Each treatment plan (initial and update) is individualized.	75%
There is evidence that the assessment is used in developing the treatment plan and goals.	75%
Each treatment plan (initial and update) states the participant's problems.	75%
Each treatment plan (initial and update) states the participant's needs.	75%
Each treatment plan (initial and update) states the participant's strengths.	75%
Each treatment plan (initial and update) has objective and measurable short and long term goals.	0%
Each treatment plan (initial and update) includes estimated time frames for goal attainment.	75%
Each treatment plan (initial and update) includes medically necessary interventions.	75%

Each treatment plan (initial and update) includes a schedule of clinical services, including individual, group, and family.	50%
When applicable, the treatment plan (initial and update) reflects discharge/transition planning.	25%
The treatment plan is reviewed and updated at regular intervals.	75%
Each treatment plan (initial and update) is developed with participation of the participant.	75%
Each treatment plan review documents progress towards goals.	75%
The record includes a safety plan, completed with the participant, when active risk issues are identified.	52%
Each treatment plan (initial and reviews) includes documentation that the participant or parent/legal guardian was offered a copy of the plan and if they accepted or declined.	50%
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.	75%
Each treatment plan (initial and review) is signed by the alcohol and drug counselor.	75%
Each treatment plan (initial and review) is reviewed and approved by a licensed physician or licensed practitioner of the healing arts.	75%
All progress/contact notes document the start time and end time the service was rendered.	75%
All progress/contact notes document the location where service was rendered.	67%
All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.	75%
All progress/contact notes document clearly who is in attendance during each session.	75%
All progress/contact notes document the participant's mental status.	50%
All progress/contact notes contain a summary of interventions.	75%
All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.	75%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	58%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	73%
The progress/contact notes reflect reassessments, when necessary.	58%
The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).	75%
The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.	64%
The progress/contact notes document the dates of follow-up appointments.	50%
The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.	71%
For Opioid Treatment Program: The record documents the ordered dosing schedule.	75%
For Opioid Treatment Program: The record documents that medications were administered/dispensed according to the licensed practitioner's medication order.	75%
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.	23%

For Opioid Treatment Program: The record contains the documentation of the guest dosing history and notification of any concerns, if any.	23%
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.	50%
If the participant is on medication, there is evidence of medication monitoring in the treatment record.	75%
The record contains evidence that toxicology tests were ordered, and the results.	75%
When toxicology results are positive, the record contains documentation that results were addressed by staff with the participant, and appropriate action was taken.	75%
If the participant has a PCP, there is documentation that communication/collaboration occurred.	92%
If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.	75%
If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.	38%
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.	17%
For all discharged participants, the discharge summary documentation is comprehensive.	66%
For all discharged participants, the discharge plan describes specific follow-up activities.	66%
Clinical records are completed within 30 days following discharge.	66%
Overall Average	62%

Psychiatric Rehabilitation Program for Adults (PRP-A)	
Quality Line Item	**Average Score**
Each participant has a separate record.	97%
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.	83%
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.	86%
The record is clearly legible to someone other than the writer.	98%
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.	76%
The record contains legal documentation to verify that the consent was given by the appropriate person.	69%
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.	62%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	67%
The record contains documentation of entitlements that the participant receives, including amounts.	42%
The record contains documentation that the participant or parent/legal guardian applied for the entitlements for which the participant may be eligible, and the outcome.	34%
The record contains documentation of how the program assisted the participant or parent/legal guardian in applying for entitlements, if the application was not already submitted.	25%
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.	56%
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.	63%
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.	57%
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.	68%
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.	36%
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).	37%
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.	45%
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.	25%
For PRP-A/M and Mobile Treatment: The record contains a screening assessment, to determine whether services are medically necessary.	63%
For PRP-A/M: The record contains documentation that the determination of appropriateness and admission to the program, following screening, was provided in writing to the participant or parent/legal guardian.	49%
The record contains an individualized assessment.	71%
The assessment includes the participant or family's presenting problem.	53%
The assessment includes the participant or family's history.	56%

The record contains documentation of the participant's medical history.	72%
The medical history includes family history information.	35%
The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.	60%
The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	59%
The behavioral health treatment history includes family history information.	47%
The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.	59%
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.	61%
The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	62%
For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.	62%
For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.	65%
The assessment includes an assessment for depression.	40%
The assessment documents the spiritual variables that may impact treatment.	38%
The assessment documents the cultural variables that may impact treatment.	33%
An educational assessment appropriate to the age and level of care is documented.	68%
The record documents the presence or absence of relevant legal issues of the participant and/or family.	68%
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.	54%
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.	71%
For participant 12 and older, the substance use screening includes documentation of past and present use of nicotine.	41%
If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.	52%
The record contains reassessments, when necessary.	52%
For PRP-A/M: The assessment includes documentation of the participant's age and strengths, skills, and needs for age-appropriate domains.	72%
An initial treatment plan is established at each level of care.	83%
Each treatment plan (initial and update) is individualized.	83%
There is evidence that the assessment is used in developing the treatment plan and goals.	76%
Each treatment plan (initial and update) states the participant's problems.	74%
Each treatment plan (initial and update) states the participant's needs.	72%
Each treatment plan (initial and update) states the participant's strengths.	70%

Each treatment plan (initial and update) has objective and measurable short and long term goals.	58%
Each treatment plan (initial and update) includes estimated time frames for goal attainment.	72%
Each treatment plan (initial and update) includes medically necessary interventions.	78%
When applicable, the treatment plan (initial and update) reflects discharge/transition planning.	73%
The record indicates the participant's involvement in treatment planning.	80%
When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.	45%
The treatment plan is reviewed and updated with the participant or parent/legal guardian (if applicable) at regular intervals.	79%
The treatment plan is updated whenever goals are achieved or new problems are identified.	77%
Each treatment plan review documents progress towards goals.	61%
The record includes a safety plan, completed with the participant, when active risk issues are identified.	66%
Each treatment plan (initial and reviews) includes documentation that the participant or parent/legal guardian was offered a copy of the plan and if they accepted or declined.	59%
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.	74%
Each treatment plan (initial and reviews) are signed by the provider.	80%
All progress/contact notes document the start time and end time the service was rendered.	88%
All progress/contact notes document the location where service was rendered.	86%
All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.	77%
All progress/contact notes document clearly who is in attendance during each session.	91%
All progress/contact notes contain a summary of interventions.	82%
All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.	86%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	79%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	45%
The progress/contact notes reflect reassessments, when necessary.	64%
The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).	30%
The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.	19%
The progress/contact notes document the dates of follow-up appointments.	24%
The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.	69%
For PRP-A/M: The record contains monthly progress notes, which documents achievement of progress towards goals, incorporating the perspective of the participant and involved staff; changes in the participant's status; and a summary of rehabilitation services and interventions provided.	56%

If the participant has a PCP, there is documentation that communication/collaboration occurred.	40%
If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.	69%
If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.	56%
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.	54%
For all discharged participants, the discharge summary documentation is comprehensive.	65%
For all discharged participants, the discharge plan describes specific follow-up activities.	59%
Clinical records are completed within 30 days following discharge.	75%
Overall Average	64%

Psychiatric Rehabilitation Program for Minors (PRP-M)	
Quality Line Item	**Average Score**
Each participant has a separate record.	68%
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.	63%
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.	57%
The record is clearly legible to someone other than the writer.	73%
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.	65%
The record contains legal documentation to verify that the consent was given by the appropriate person.	36%
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.	43%
The record contains documentation that the participant over the age of 18 was given information on, or declined assistance with making an advance directive.	47%
The record contains documentation of entitlements that the participant receives, including amounts.	0%
The record contains documentation that the participant or parent/legal guardian applied for the entitlements for which the participant may be eligible, and the outcome.	0%
The record contains documentation of how the program assisted the participant or parent/legal guardian in applying for entitlements, if the application was not already submitted.	0%
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.	61%
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.	45%
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.	50%
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.	0%
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).	0%
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.	0%
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.	0%
For PRP-A/M and Mobile Treatment: The record contains a screening assessment, to determine whether services are medically necessary.	42%
For PRP-A/M: The record contains documentation that the determination of appropriateness and admission to the program, following screening, was provided in writing to the participant or parent/legal guardian.	45%
The record contains an individualized assessment.	47%
The assessment includes the participant or family's presenting problem.	0%
The assessment includes the participant or family's history.	0%
The record contains documentation of the participant's medical history.	48%

The medical history includes family history information.	25%
The record contains documentation of the presence or absence of the participant's drug allergies and food allergies, and adverse reactions.	42%
The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.	27%
The behavioral health treatment history includes family history information.	35%
The behavioral health history includes an assessment of any abuse the participant has experienced or if the participant has been the perpetrator of abuse.	44%
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.	42%
The record includes documentation of previous suicidal or homicidal behaviors, including dates, method, and lethality.	40%
For Adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.	17%
For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.	38%
The assessment includes an assessment for depression.	40%
The assessment documents the spiritual variables that may impact treatment.	22%
The assessment documents the cultural variables that may impact treatment.	20%
An educational assessment appropriate to the age and level of care is documented.	41%
The record documents the presence or absence of relevant legal issues of the participant and/or family.	43%
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.	40%
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.	32%
For participant 12 and older, the substance use screening includes documentation of past and present use of nicotine.	11%
The record contains reassessments, when necessary.	42%
For PRP-A/M: The assessment includes documentation of the participant's age and strengths, skills, and needs for age-appropriate domains.	20%
An initial treatment plan is established at each level of care.	60%
Each treatment plan (initial and update) is individualized.	60%
There is evidence that the assessment is used in developing the treatment plan and goals.	42%
Each treatment plan (initial and update) states the participant's problems.	50%
Each treatment plan (initial and update) states the participant's needs.	43%
Each treatment plan (initial and update) states the participant's strengths.	42%
Each treatment plan (initial and update) has objective and measurable short and long term goals.	58%
Each treatment plan (initial and update) includes estimated time frames for goal attainment.	60%

Each treatment plan (initial and update) includes medically necessary interventions.	60%
When applicable, the treatment plan (initial and update) reflects discharge/transition planning.	27%
The record indicates the participant's involvement in treatment planning.	58%
When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.	62%
The treatment plan is reviewed and updated with the participant or parent/legal guardian (if applicable) at regular intervals.	58%
The treatment plan is updated whenever goals are achieved or new problems are identified.	56%
Each treatment plan review documents progress towards goals.	53%
The record includes a safety plan, completed with the participant, when active risk issues are identified.	45%
Each treatment plan (initial and reviews) includes documentation that the participant or parent/legal guardian was offered a copy of the plan and if they accepted or declined.	45%
Each treatment plan (initial and reviews) are signed by the participant or parent/legal guardian.	55%
Each treatment plan (initial and reviews) are signed by the provider.	56%
All progress/contact notes document the start time and end time the service was rendered.	58%
All progress/contact notes document the location where service was rendered.	58%
All progress/contact notes include documentation of the billing code, or specific service rendered, that was submitted for the session.	52%
All progress/contact notes document clearly who is in attendance during each session.	57%
All progress/contact notes contain a summary of interventions.	43%
All progress/contact notes document services were rendered appropriate to the level of care/program, and in accordance with the treatment/behavior plan.	58%
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).	17%
The progress/contact notes describe progress or lack of progress towards treatment plan goals.	40%
The progress/contact notes reflect reassessments, when necessary.	45%
The progress/contact notes document on-going risk assessments (including but not limited to suicide and homicide).	40%
The progress/contact notes document provider follow-up or intervention when an active risk issue is identified.	5%
The progress/contact notes document the dates of follow-up appointments.	17%
The progress/contact notes document when participants miss appointments, including efforts made to outreach the participant.	28%
For PRP-A/M: The record contains monthly progress notes, which documents achievement of progress towards goals, incorporating the perspective of the participant and involved staff; changes in the participant's status; and a summary of rehabilitation services and interventions provided.	50%
If the participant has a PCP, there is documentation that communication/collaboration occurred.	86%
If the participant is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.	56%

If the participant was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.	9%
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.	9%
For all discharged participants, the discharge summary documentation is comprehensive.	30%
For all discharged participants, the discharge plan describes specific follow-up activities.	32%
Clinical records are completed within 30 days following discharge.	33%
Overall Average	42%