Optum - Behavioral Network Services

Program Quality Improvement Self-Assessment Tool - Individual Practitioner

Present in Chart?	Y	N	NA
General Documentation Standards			
Each participant has a separate record.			
The record includes documentation of the following: Participant's gender (assigned and/or identified); address; employer or school; home and work telephone numbers, including emergency contacts; relationship or legal status; and guardianship information, if relevant.			
All entries in the record include the responsible service provider's name, and title and credentials; and are dated and signed (including electronic signature for EHR systems), where appropriate.			
The record is clearly legible to someone other than the writer.			
The record contains a Consent for Treatment or Informed Consent that is signed by the participant or parent/legal guardian in advance of treatment; and legal documentation to verify that consent was given by the appropriate person, when consents are signed by a legal guardian.			
The record contains documentation that the provider informed the participant of: the purpose and nature of an evaluation or treatment process; the additional options to the proposed treatment; the potential reactions to the proposed treatment; the right to withdraw from treatment at any time, including the possible risks that may be associated with withdrawal; and the fees for service, including that Maryland Medicaid are exempt from any additional out-of-pocket fees (when additional fees are listed).			
For participants being prescribed medication by this provider: The record contains documentation that the provider educated the participant or parent/legal guardian about the risks, benefits, side effects, and alternatives of each medication, and the participant or parent/legal guardian understands the medication(s) being prescribed.			
For participants receiving substance use treatment from this provider: The record contains a completed Maryland Medicaid/Maryland Department of Health/Optum Maryland *Authorization to Disclose Substance Use Treatment Information for Coordination of Care* form, or documentation that the participant refused to sign the form.			

For uninsured participants: The record contains a completed MDH *Documentation for Uninsured Eligibility Registration* form, and verification of uninsured eligibility status or documentation of approval by MDH to bill uninsured.			
For participants seen via telehealth/telephonic means: The record contains documentation that the participant or parent/legal guardian was fully informed of all of the following: the terms, limits, security-confidentiality risks of HIPAA-compliant and non-HIPAA-compliant telehealth and/or telephonic service transmission; the type of transmission services will be provided by (telehealth, telephonic); and the risks associated, if services will be provided via non-HIPAA-compliant transmission.			
Psychologist and Counselor Specific			
For psychologists and counselors involved in research: The record contains an Informed Consent that is signed by the participant or parent/legal guardian, in advance of treatment, containing documentation that the participant or parent/guardian was fully informed of: the nature of participation, that treatment is given as part of a research study; the right to decline treatment, if part or all of the treatment is to be recorded for research or review by another person, without implication that a penalty may result in refusal to participate; and that permission will be obtained prior to electronic recording or observation by another person.			
For psychologists: The record documents the participant's original test data, with results and other evaluative material.			
For psychologists: The record documents the results of any formal consultations with other professionals.			
Initial Assessment			
The record contains an individualized assessment, completed by the provider.			
The assessment includes the participant or family's presenting problem.			
The assessment includes both the diagnosis, based on DSM-V, and a rationale for the diagnosis.			
The assessment contains a complete mental status exam.			

The record contains comprehensive documentation of the participant's medical history, including: the presence or absence of the participant's drug allergies and food allergies, and adverse reactions; and family medical history information.			
The record contains comprehensive documentation of the participant's behavioral health history, including: dates and providers of previous treatment, and therapeutic interventions and responses; an assessment of any abuse the participant has experienced, and/or if the participant has been the perpetrator of abuse; previous suicidal or homicidal behaviors, including dates, method, and lethality; and family behavioral health history information.			
The record contains documentation of a risk assessment of the presence or absence of suicidal or homicidal risk and danger toward self or others; and a safety plan, completed with the participant, when active risk issues are identified.			
For adolescents (aged 12 to 18 years): The assessment documents a sexual behavior history.			
For children and adolescents: The assessment documents prenatal and perinatal events, and a complete developmental history (physical, psychological, social, intellectual and academic).			
The assessment documents both spiritual and cultural variables that may impact treatment			
The record documents the presence or absence of relevant legal issues of the participant and family.			
The record contains a substance abuse screening of past and present use of nicotine, alcohol, illicit drugs, and prescription and over-the-counter medications; and documentation that an intervention for substance use occurred, when an active alcohol or substance use problem is indicated.			
Treatment Planning			
An initial treatment plan is established at each level of care, with the participant's participation, based on the assesment.			
Each treatment plan (initial and update) is individualized.			
Each treatment plan (initial and update) includes: the participant's problems, needs, and strengths; measurable short and long-term goals; estimated time frames for goal attainment; medically necessary interventions; and discharge planning.			

The treatment plan is reviewed at regular intervals and updated with the participant's or parent/legal guardian's participation, and includes documentation of: updates, whenever goals are achieved or new problems are identified; progress towards goals; and signature by both the provider and either the participant or parent/legal guardian.			
Progress/Contact Notes			
All progress/contact notes document the start time and end time the service was rendered.			
All progress/contact notes document the location where service was rendered.			
All progress/contact notes document clearly who is in attendance during each session.			
All progress/contact notes document the participant's mental status.			
All progress/contact notes contain a summary of interventions.			
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).			
The progress/contact notes describe progress or lack of progress towards treatment plan goals.			
The progress/contact notes document on-going risk assessments, including but not limited to suicide and homicide; and intervention when an active risk issue is identified.			
Evaluation and Management (E&M) - Physicians and Nurse Practitioners only			
Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription and refills.			
If the participant was prescribed a controlled substance, there was evidence in the record the prescriber utilized the Chesapeake Regional Information System for our Patients (CRISP) prior to prescribing.			

If the participant is on medication, there is evidence of medication monitoring in the treatment record.			
When lab work is ordered, there is evidence the lab results were received and reviewed by the prescribing provider.			
Coordination of Care			
If the participant has a PCP and has signed a Release of Information, there is documentation that communication/collaboration occurred with the PCP. If the record does not contain a signed Release of Information, refusal to sign one is documented.			
If the participant is being seen by another behavioral health provider and has signed a Release of Information, there is documentation that communication/collaboration occurred with the provider. If the record does not contain a signed Release of Information, refusal to sign one is documented.			
Discharge and Transfer			
For discharged participants: The record contains a discharge summary, completed within 30 days of discharge, that includes documentation of communication/collaboration with the receiving clinician/program, and specific follow-up activities.			