Optum - Behavioral Network Services

Program Quality Improvement Self-Assessment Tool - Substance Use Disorder Program

Present in Chart?	Y	N	NA
General Documentation Standards			
Each participant has a separate record.			
The record includes the participant's gender (assigned and/or identified), address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
All entries in the record include the responsible service provider's name, title and credentials, and are dated and signed (including electronic signature for EMR systems), where appropriate.			
The record is clearly legible to someone other than the writer.			
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 participant over the age of 18 was given information on, or declined assistance with making an advance directive.			
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/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.			

Initial Assessment

The record contains an individualized assessment.		
The assessment includes the participant's presenting problem.		
The assessment includes the diagnosis, based on DSM-V.		
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: the 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.		
The assessment documents both spiritual and cultural variables that may impact treatment		
The assessment documents a recommendation for appropriate level of substance use disorder treatment.		
The participant meets ASAM criteria for the recommended level of substance use disorder treatment, and is enrolled in the recommended level of substance use treatment.		

The assessment contains referrals for physical and mental health services.			
The record contains documentation that the participant completed an infectious disease risk assessment, and was referred to counseling and/or testing, as appropriate; and received infectious health education.			
Treatment Planning			
An initial treatment plan is established at each level of care, with the participant's participation, based on the assessment.			
Each treatment plan (initial and update) is individualized.			
Each treatment plan (initial and update) includes: the participant's problems, needs, and strengths; short and long-term goals; estimated time frames for goal attainment; medically necessary interventions; a schedule of clinical services, including individual, group, and family; and discharge/transition planning (when applicable).			
The treatment plan is reviewed at regular intervals and updated with the participant's or parent/legal guardian's participation, and includes documentation of: progress towards goals; signature by both the provider and either the participant or parent/legal guardian; that the participant or parent/legal guardian was offered a copy of the plan, and if they accepted or declined; and was reviewed and approved by a licensed physician or licensed practitioner of the healing arts.			
Progress/Contact Notes			
All progress/contact notes document the start time and end time the service was rendered.			
All progress/contact notes document the location where service was rendered.			
All progress/contact notes document clearly who is in attendance during each session.			
All progress/contact notes document the participant's mental status.			

All progress/contact notes contain a summary of interventions.			
All progress/contact notes document that services were rendered appropriate to the level of care/program, and in accordance with the treatment plan.			
The progress/contact notes document any referrals made to other clinicians, agencies, and/or therapeutic services (when clinically indicated).			
The progress/contact notes describe progress or lack of progress towards treatment plan goals.			
The progress/contact notes document on-going risk assessments, including but not limited to suicide and homicide; and intervention, when an active risk issue is identified.			
The record contains documentation that the participant received the minimum required hours for the program level of treatment they are enrolled in.			
For SUD Residential Levels 3.1, 3.3, 3.5, and 3.7: The record contains weekly progress notes, at the end of each week that service is provided, that shows objective progress towards goals.			
Dosing and Drug Screening			
For Opioid Treatment Program: The record documents the ordered dosing schedule, and that medications were administered/dispensed according to the licensed practitioner's medication order.			
For Opioid Treatment Program: If the participant utilized guest dosing, the record contains the home (original OTP referral to the program in which the participant will receive guest dosing) order/referral for guest dosing; and documentation of the guest dosing history and notification of any concerns, if any.			
If the participant was prescribed a controlled substance, there was evidence in the record the prescriber utilized the Chesapeake Regional Information System for our Patients (CRISP) prior to prescribing.			
If the participant is on medication, there is evidence of medication monitoring in the treatment record.			
The record contains evidence that toxicology tests were ordered, and the results.			

When toxicology results are positive, the record contains documentation that results were addressed by staff with the participant, and appropriate action was taken.			
Coordination of Care			
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.			