D&A Outpatient AUDIT TOOL

QUESTIONS	DEFINITIONS
1. Each page in the treatment record contains the member's name or MA ID number.	Each page in the treatment record contains the enrollee's name or ID number.
2. Each treatment record includes the member's required demographics.	a. Member's address, b. Telephone # c.Emergency contact. d. School name, if applicable.
3. Each treatment record includes the adult member's marital status, legal status, and guardianship information, if applicable.	(**D&A - ask for all ages > 13.)** a. Marital status. b. Legal status issues such as DUI, probation or pending legal action if applicable. c. Guardianship, if applicable.
4. Each treatment record contains PCP notification or declination.	Each chart should contain a release to notify the member's PCP of their involvement in treatment with the evidence of notification **OR** documentation of the member's declination of PCP notification.
5. Each treatment record contains the • HIPAA Privacy Notice, • appropriate releases and • Consent for treatment, signed or initialed by the member.	Statement of confidentiality or a HIPAA Notice of Privacy Practices is found in the medical record or there is documentation in the member's record that the member has received a copy of the Notice of Privacy Practices. Chart also must contain a signed consent for treatment and any releases that may be appropriate.
6. All entries in the treatment record must be signed by the responsible clinician.	Full signature of clinician, and degree or relevant identification number must appear after each entry. If signature is stamped, score 'no'. If records are electronic, a unique electronic identifier is acceptable. If clinician is an ancillary staff person, all entries must be countersigned by the responsible licensed provider.
7. All entries in the treatment record are dated.	Day, month and year on each entry
8. The treatment record is legible to someone other than the writer.	Entries can be read at a normal pace. Reviewer is not required to excessively figure out individual words or phrases.

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9. Presenting problems, along with relevant psychological and social conditions affecting the member's medical and psychiatric status, are documented in the treatment record.	a. Presenting problems, b. Current symptoms, c. History of symptoms, d. Problem behaviors, e. Relevant psycho-social conditions affecting the patient's medical and psychiatric status are documented in the assessment
10. Is there evidence of an assessment that includes a member's previous treatment history, treatment interventions, response to treatment and length of clean time.	**Treatment history includes interventions such as types of therapy and levels of care such as OP, IOP, PHP, HWH, res. Detox or rehab.**
11. Relevant medical conditions (including pregnancy) are listed, prominently identified, and revised as appropriate in the treatment record	If a medical condition addressed on Axis 3 or in PCPC is identified as a presenting problem in the assessment, it must be addressed in the treatment plan and the progress notes
12. *Food, drug, environmental allergies* and adverse reactions or no known allergies are clearly documented in the treatment record.	Documentation of allergies, or no known allergies NKA, any adverse reactions, any sensitivity to pharmaceuticals or other substances are documented. Non-prescribing practitioners must document allergy and adverse reaction information upon initial assessment and show evidence of appropriate follow up, if indicated.
13. The treatment record indicates prescribed medications, the dates prescribed, and dosages.	For prescribers all of the following elements must be present: a. Medications prescribed, b. Dosages of each, c. Dates of initial prescriptions and refills. For non-prescribing practitioners, each treatment record should indicate: a. What medications have been prescribed, b. The name of the prescriber. N/A if medications are not prescribed.
14. There is evidence of a psychiatric evaluation when medication is prescribed at the facility.	If prescribed by a psychiatrist, a psychiatric evaluation is required at the time of the medication prescription. If prescribed by a PCP, a rationale for the medication must be documented. N/A if not a prescriber
15. If medication is prescribed, there is evidence of medication education and understanding by the patient, or for a minor child, the parent /guardian.	Documentation of the risks and benefits to the patient must be present.

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16. A medical and psychiatric history is documented in the treatment record, *that may include* previous treatment dates, hospitalizations, provider identification, therapeutic interventions and responses, relevant family information, results of laboratory tests, and consultation reports.	**D&A: Medical history must be documented in the chart** A family history in which the presence or absence of psychiatric and /or substance abuse history among family members may also be part of the psychiatric history.
17. Documentation in the treatment record includes past and present use of cigarettes, alcohol, illicit drugs and abuse of prescribed or over-the-counter drugs.	**D&A: This must include substances used, route, age first used, amounts and last use.**
18. **Is there evidence of an assessment of possible substance abuse among family members?”**	**No N/A**
19. Are updates/changes reflected in the progress notes from the most recent assessment?	**Re-assessment of symptoms** should occur in each documented contact.
20. A DSM-IV/ICD9 diagnosis, is documented with a signature and date from the evaluator.	**For D&A/ OP: AXIS I is the minimum standard.** If a dual program , must have all five Axis
21. Treatment plans: 1) must be individualized 2) have measurable goals & objectives and identification of person responsible and modality. 3) have estimated time frames for goal attainment or problem resolution 4) signed by clinician/treatment team and the member.	Plan must have documentation of specific behaviors/symptoms to be addressed which have been identified in the initial assessment/psych eval, or **PCPC** and relate directly to the diagnosis. Goals must be measurable with stated outcomes and time frames to accomplish the goals.
22. The treatment plan meets timeframe standards for initial development and update/review.	**D&A/OP: 1st plan within 15 days and every 60 days after that.**
23. Treatment plan goals and objectives are reflected in the progress notes.	Each progress note should be directly related to the treatment goal being addressed during that contact. Treatment goals should be identified, addressed and prioritized.
24.Documentation of progress or lack of progress **must be** found in the progress notes.	Documentation of progress or lack of progress must be found in the progress notes, updated treatment plan, and discharge summary. Progress notes should identify interventions used, treatment modality, response of member to interventions and plan to address the issues going forward

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25. Is there evidence that the member was referred to an appropriate level of care if an enrollee experienced a crisis during the treatment period?	Member becomes suicidal, homicidal or there is a significant change from baseline ability to conduct activities of daily living such as relapse. Score N/A if no crisis is identified.
26. The treatment record documents preventive services, as appropriate, relapse prevention, stress management, wellness programs, lifestyle changes, and referrals to community resources.	Documentation of the clinician's efforts to educate the patient about approaches that might augment treatment being provided such as relapse prevention, stress or anger management, wellness program, lifestyle changes, social skills, community resources or AA.
27. The discharge plan has been documented and updated.	**Score N/A for MH or D&A outpatient charts**.
28. Closed Chart/ Member's discharge instructions are documented in the chart.	**NA for Outpatient levels of care.**
29. There is evidence that the clinical assessment is culturally relevant (i.e. addresses issues relevant to the member's race, religion, ethnicity, age, gender, sexual orientation, level of education, socio-economic level).	Cultural issues identified as a presenting problem in the assessment must be included in the treatment plan. N/A if none are identified.
30. The treatment record has evidence of continuity and coordination of care between behavioral health institutions, practitioners, ancillary providers, consultants, outpatient behavioral health practitioners or EAP/employer if indicated.	If dually diagnosed, check for a referral to MH or D&A. Documented evidence of attempts to coordinate care. Look for appropriate releases.
31. Closed Charts: A discharge summary/aftercare plan has been documented at the conclusion of treatment.	a. Discharge diagnosis, b. Medications, dosages and frequency if applicable, c. status of goals, d. Treatment summary, e. Barriers to treatment if applicable, f. Crisis plan/relapse prevention plan as applicable, g. Ancillary services as applicable. Score N/A if not a closed chart
32. For children and adolescents, prenatal and perinatal events, along with a complete developmental history including physical, psychological, social, intellectual, and academic are documented in the treatment record.	**NA for D&A** Developmental history includes: a. Physical, b. Psychological, c. Social, d. intellectual, e. Academic domains. (N/A if the child is over the age of 18

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33. Each treatment record includes the child's legal status and guardianship information	**NA for D&A** 1a. Probation, pending legal issues such as DUI, b. Marital status of the parent /guardian, c. Name and phone # of the individual/agency that has legal custody of the child if other than the biological or adoptive parents.
34. **For D&A OP: Has the current living environment of the member been assessed?**	
35. The record indicates the parent(s), legal guardian or caretaker(s) have given signed consent for the various treatments provided.	**NA for D&A Parent consent for treatment is not required for members 14 or older**. For substance abuse treatment of children, only the minor needs to sign the informed consent. No age restrictions for substance abuse treatment.
36. **For D&A OP: Has the current support system of the member been assessed?**	
37. The record shows evidence of coordination with the youth's school to achieve school related treatment goals.	**NA for D&A** f a child is receiving special education, a copy of the IEP must be in the medical record. Evidence that collaboration with the youth's school has occurred if there are treatment goals related to school functioning. (N/A if treatment goals are not related to school functioning.)

Access Standard Review	DEFINITIONS
57. Type of appointment: _______ emergency _______ urgent _______ routine. Standard Met? (circle one) YES NO	Answer this item for Outpatient Access Standards. Emergency: 1 hour, Urgent: 24 hours, Routine: 7 days
58. Number of days from the member's call to first offered appointment.	Answer this item for Outpatient Access Standards. Number of days from the member's call to the offered appointment. Score N/A for emergency and urgent appointments.
59.Number of days from member's call to actual appointment.	Answer this item for Outpatient Access Standards. Number of days from the member's call to the actual appointment. Score N/A for emergency and urgent appointments

60.List the reason that the standard was not met. • No appt Available ________________ • Appt offered within 7 days but patient chose another date. _______________ • Other___________________________ _______________________________	Answer N/A if access standard is met. Possible reasons for not meeting standard: First available appointment with provider, member request, request for a specific therapist, reason not documented by the provider, or other- List other.