***Family-Based Mental Health Services***
PROVIDER CHART AUDIT TOOL

**Provider Name:**

_____________________________________________

**Review Type / Level of Care:**

____________________________________________

**Child______ Adult______**

**Address ____________________________________**

**City ________________________________________**

**State ____ Zip _________________**

**Phone # ____________________________**

**Fax # ____________________________**

**Provider ID Number: __________________**

**Vendor ID Number: __________________**

**Site Contact Name:**

____________________________________________

**Reason for Review** (please check one): Routine Clinical Record Review ☐ Quality of Care Review ☐
Action Plan Follow-up ☐ Recredentialing ☐ Other ☐ ____________________________

OPEN _____ CLOSED ______



*Prepared by Value Behavioral Health of PA*
Revised for FB; 2005, 2007; 2009; revised format 9/20/2011

| **Enter the record identifier:** MA ID ___________________________________<br><br>**Enter the member's age** _____ **DOB:** ___________________ **County:** _____________________ | |
|---|---|
| List all AXIS I diagnoses _________________________________________________<br>_________________________________________________<br>_________________________________________________<br>_________________________________________________ | |
| AXIS II ______________________________________________________________<br><br>AXIS III ______________________________________________________________<br><br>AXIS IV ______________________________________________________________<br><br>AXIS V ______________________________________________________________<br><br>Date of above diagnosis _______________________________________________<br><br>Name & degree of evaluator ___________________________________________ | Note if any are missing. Score under question 20. |

**FOR DIAGNOSIS, USE THE MOST RECENT DIAGNOSIS THAT IS SIGNED AND DATED BY AN EVALUATOR (AN M.D. OR PhD)**



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| | 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 member'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, as applicable. |
| 3. | Each treatment record includes the adult member's marital status, legal status, and guardianship information, if applicable. | N/A for FBMHS.<br>Adult question only: a. Marital status. b. Legal status issues such as DUI, probation or pending legal action if applicable. c. Guardianship if member is declared incompetent. |
| 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 and 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. Family Based: For children in foster care, consent must be secured from biological family or CYS. |
| 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. |
| 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. | Special status situations, such as imminent risk of harm, suicidal ideation, or elopement potential, are prominently noted, documented and revised in the treatment record. | Evidence that the enrollee was thoroughly evaluated upon initial assessment as to dangerousness to self, to others or elopement potential. b. Special status situations should be addressed at each documented contact by MHP, nurse or psychiatrist in the progress notes until resolved. |

| QUESTIONS | | DEFINITIONS |
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| 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 is identified as a presenting problem in the assessment, it must be addressed in the treatment plan and the progress notes. (N/A if medical condition is not identified as a presenting problem). |
| 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. | N/A if medications are not prescribed by this provider. 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.. There must be a documented rationale for medication changes (type, dosage). |
| 14. | There is evidence of a psychiatric evaluation when medication is prescribed at the facility. | Score N/A for Family Based 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. | Score N/A for Family Based Documentation of the risks and benefits to the patient must be present. N/A, if medication is not prescribed or the practitioner being reviewed is not a prescriber. |
| 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. | 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. | N/A for a child under 6. May include over the counter drugs such as ephedrine, herbal supplements, melatonin, St. John's Wort. |
| 18. | A mental status that includes the member's affect, speech, mood, thought content, judgment, insight, attention span/concentration, memory and impulse control is documented. | A minimum of 7 of the 9 elements must be present.<br>FBMHS: If the mental status exam is found in the psych evaluation it will be accepted; if not in the psych evaluation, then mental status must be documented by the clinician somewhere else in the record. |

| QUESTIONS | | DEFINITIONS |
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| 19. | Documentation of progress or lack of progress must be found in the progress notes. | FBMHS – The clinical documentation must include: 1) details of any new significant clinical information as result of contact (treatment plan should reflect integration of new information); 2) documentation of progress on identified goal(s) for each contact and goal(s) for next scheduled contact; and 3) details of barriers to progress in treatment, and the plan to address barriers. |
| 20. | A DSM-IV/ICD9 diagnosis, is documented with a signature and date from the evaluator. | All 5 axes must be present. |
| 21. | Treatment plans: 1) must be individualized 2) have measurable goals and objectives and identification of person responsible and modality 3) have estimated time frames for goal attainment or problem resolution 4) are signed by clinician/treatment team and the member. | Plan must have documentation of specific behaviors / symptoms/needs to be addressed which have been identified in the initial assessment/psych eval and relate directly to the diagnosis. Goals must be measurable with stated outcomes and time frames to accomplish the goals. Must be signed by the treatment team and the member.<br>FBMHS: Family participation is evidenced by signature on treatment plan. Family Based supervisor must review, date and sign the initial and updated treatment plans. |
| 22. | The treatment plan meets timeframe standards for initial development and update/review. | Time frame standards for:<br>*Family Based*: The initial plan must be developed within 5 calendar days of obtaining consent to treatment; the comprehensive tx plan must be completed and signed within 30 calendar days of obtaining consent to treatment. There is written evidence that goals and progress are reviewed every 30 calendar days, as evidenced by signatures of clinician, supervisor, and family. Any exception to the above time frames requires documentation explaining the time delay. |
| 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. Tx goals should be identified, addressed and prioritized (addressing goals that are most concerning/problematic unless specifically documented). Notes should identify interventions used, treatment modality, response of member to interventions and plan to address the issues going forward.<br><br>FBMHS – If treatment goals are modified, the rationale for the changes is documented. |

| QUESTIONS | | DEFINITIONS |
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| 24. | There is evidence in the record that the clinician is following up with no-shows AND is addressing the issue of missed appointments with the members during therapy sessions. | N/A if member does not have a history of no-shows. |
| 25. | FBMHS: A documented crisis/safety plan specific to the needs of the family is included in the record. | If member becomes suicidal, homicidal or there is a significant change from baseline ability to conduct activities of daily living such as relapse.<br><br>FBMHS: The crisis/safety plan includes the definition of the crisis, triggers as identified by the family and/or the member, contact information, and specific suggested interventions. The crisis/safety plan is completed and signed within 30 days of consent to treatment, and is reviewed monthly (evidence of review is documented in the record).<br>If a crisis occurred, documentation of how stabilization was achieved and documented updates to the crisis plan based on results. |
| 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. FBMHS – engaging parent and child in community resources, referrals for advocate/school assistance/med management as applicable. |
| 27. | The discharge plan has been documented and updated. | Planning should begin on the day of admission and continues throughout treatment.. For FBMHS, evidence of advance discharge planning is found in the record. Planning information is documented in a separate note, either in the progress notes, goal review or discharge summary. Discharge plans are reviewed monthly. |
| 28. | Closed Chart/ Member's discharge instructions are documented in the chart. | N/A for Family Based |
| 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. | Documented evidence of attempts to coordinate care. Look for appropriate releases. If dually diagnosed, check for a referral to MH or D&A. |

| QUESTIONS | | DEFINITIONS |
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| 31. | Closed Charts **only:** 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.<br>Family Based: The discharge summary should include referrals to aftercare providers, follow-up appointment dates and times, level of functioning/severity of symptoms at time of discharge, and discharge date. |
| 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. | 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) |
| 33. | Each treatment record includes the child's legal status and guardianship information | a. 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. | The record reflects the active involvement of the family, legal guardian or primary caretakers in the assessment and treatment of the enrollee, unless contraindicated. | Family involvement is documented unless contraindicated. Look for parent/guardian signature on the treatment plan and documentation of family involvement in the treatment notes. |
| 35. | The record indicates the parent(s), legal guardian or caretaker(s) have given signed consent for the various treatments provided. | 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. | The record shows evidence of an assessment of school functioning. | Evidence that the youth's school/parent/guardian was contacted for academic and behavioral data. Look for release of information to contact the school. Score N/A if child is not of school age, not enrolled in school, or if it is documented in the chart that the release of information was refused. |
| 37. | The record shows evidence of coordination with the youth's school to achieve school-related treatment goals.<br>**N/A for FBMHS** | If 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.) |

| ADDENDUM QUESTIONS | |
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| **QUESTIONS** | **DEFINITIONS** |
| A1. A comprehensive assessment is completed within 30 days of obtaining consent for treatment. | The assessment must include evidence of collateral sources, direct observation, client interview, family interview, and 2 or more objective tools (such as genograms, ecomaps, structural maps, or rating scales). The assessment must be dated and signed by the assessor within 30 days of the signed consent for treatment, and is reviewed and signed/dated by FBMHS supervisor. |
| A2. All components of FBMHS, including therapeutic interventions, contacts for case management, and crisis management are clearly documented in the treatment record. | Clinical documentation must include: a) date, time, and duration of contact; individual vs. team contact; travel time; b) type of contact (in person, telephone, therapy, crisis, and/or case management); c) location of contact; and d) individual(s) involved in contact (patient, family, other clinician, friend). |
| A3. The provider has a policy regarding the provision of services during the evenings and weekends. | The provider should have a policy regarding the provision of services during the evenings and on the weekends, due to FBMHS being intended as a 24/7 service. Mark "Yes" only if the policy was provided to and read by the auditor. |
| A4. Is there any evidence in the record that interventions/contacts were conducted during any evenings/weekends? | Evenings: after 5 p.m. Weekends: anytime on Saturday or Sunday<br>N/A if it is clearly documented that family did not want services during evenings or weekends. |
| **For aggregate analysis only:** | |
| A5. How does the provider track dates of referral to the family-based program? | Ask the provider how they track referral dates, and ask for copies of any forms on which the referral date is recorded. |