

BHRS PROVIDER CHART AUDIT

PROVIDER NAME _____ LEVEL OF CARE _____

PROVIDER ID _____

ADDRESS _____

CONTACT NAME: _____ PHONE # _____

REASON FOR REVIEW: _____ ROUTINE RECORD REVIEW (documentation)
_____ QUALITY OF CARE
_____ ACTION PLAN FOLLOW UP
_____ OTHER _____

CHART IS _____ OPEN _____ CLOSED

ATTENTION: If this audit is part of a Full Compliance Audit, please check with the Compliance Representative to determine any additional directions regarding the treatment plan, such as for 2010, are all treatment plans in the chart?
Are there any gaps in treatment plans for this year? (days or weeks)

BHRS PROVIDER CHART AUDIT

Enter the record identifier: MA ID:	
Member DOB:	Member County
List all AXIS I diagnoses: D&A treatment facilities may use a multi-axis model and/or a PCPC dimension model. _____ _____ _____ _____	
AXIS II _____	
AXIS III _____	
AXIS IV _____	
AXIS V _____	
Note if any are missing Score under question 20	
Date of above diagnosis _____	
Name and degree of evaluator _____	

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

Staff completing this chart audit

BHRS PROVIDER CHART AUDIT

QUESTIONS	DEFINITIONS
1. Each page in the treatment record contains the member's name or MAID number.	1. 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, as applicable.
3. Each treatment record includes the adult member's marital status, legal status, and guardianship information, if applicable.	BHRS N/A 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 of information to notify the member's PCP that they are in treatment. There must be documentation that the PCP was notified (such as a copy of a letter to the PCP) OR documentation that the member declined to notify the PCP.
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. BHRS: 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. TSS - not required to have a degree- may not apply for TSS
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

BHRS PROVIDER CHART AUDIT

<p>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.</p>	<p>a. 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.</p>
<p>11. Relevant medical conditions (including pregnancy) are listed, prominently identified, and revised as appropriate in the treatment record</p>	<p>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).</p>
<p>12. <i>Food, drug, environmental allergies</i> and adverse reactions or no known allergies are clearly documented in the treatment record.</p>	<p>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 if available upon initial assessment and show evidence of appropriate follow up, if indicated.</p>
<p>13. The treatment record indicates prescribed medications, the dates prescribed, and dosages.</p>	<p>(BHRS) For non-prescribing practitioners, each treatment record should indicate: a. What medications and amount have been prescribed, b. The name of the prescriber. N/A if medications are not prescribed.</p>
<p>14. There is evidence of a psychiatric evaluation when medication is prescribed at the facility.</p>	<p>Score NA BHRS 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</p>
<p>15. If medication is prescribed, there is evidence of medication education and understanding by the patient, or for a minor child, the parent/guardian.</p>	<p>Score NA BHRS 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.</p>
<p>16. A medical and psychiatric history is documented in the treatment record that <i>may include</i> previous treatment dates, hospitalizations, provider identification, therapeutic interventions and responses, relevant family information, results of laboratory tests, and consultation reports.</p>	<p>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.</p>

BHRS PROVIDER CHART AUDIT

<p>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.</p>	<p>N/A for a child under 6. Has the psychologist documented this?</p> <p>May include over the counter drugs such as ephedrine, herbal supplements, melatonin, St.John's Wort.</p>
<p>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.</p>	<p>A minimum of 7 of the 9 elements must be present.</p>
<p>19. Are updates/changes reflected in the progress notes from the most recent assessment?</p>	<p>Re-assessment of symptoms should occur in each documented contact.</p>
<p>20. A DSM-IV/ICD9 diagnosis, is documented with a signature and date from the evaluator.</p>	<p>All 5 axes must be present. For BHRS, an evaluation must be done and in the chart every 120/180 days or annually for autism spectrum disorders. Check POC for the length of plan. Evaluator must be a licensed psychologist, psychiatrist or a Masters level clinical reviewed and signed off on by above.</p>
<p>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.</p>	<p>Plan must have documentation of specific behaviors / symptoms needs to be addressed, that have been identified in the initial 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 parent/member.</p> <p>For BHRS, the treatment plan must have goals and objectives/interventions pertaining to each treatment service (TSS, MT,BSC) that is recommended in the psych evaluation The treatment plan must have documentation of a goal/objective that pertains to skill transfer to parent / guardian / child.</p>
<p>22. The treatment plan meets timeframe standards for initial development and update/review.</p>	<p>BHRS: The tx plan must be updated each review period (up to 180 days for non ASD or 1 year for ASD), with a tx plan review every 30 days with date and signature of parent/guardian and/or member.</p>

BHRS PROVIDER CHART AUDIT

<p>23. Treatment plan goals and objectives must be reflected in the progress notes.</p>	<p>Documentation for each progress note should contain: the goal(s) from the treatment plan being addressed for that encounter, progress toward the goals, identify interventions used, treatment modality, response of member/family to interventions, barriers to progress, and plan to address the issues going forward.</p> <p>Each progress note should relate to the job description of that service level (BSC, MT or TSS). BSC: observation, treatment planning, supervising; MT: Counseling, /psychoeducation TSS: carrying out treatment plan objectives developed by the BSC or MT.</p> <p>Documentation of any community activities must have a direct relation to the treatment plan with specific interventions documented to transfer skills to parent/caregiver/responsible adult (unless it is clearly documented why the skills are being transferred to the child</p>
<p>24. Documentation of progress or lack of progress must be found in the progress notes.</p>	<p>Statements of progress should include supporting data collection to verify the progress.</p> <p>There should be evidence of all treatment hours provided or documentation as to why hours were missed.</p>
<p>25. Is there a crisis safety plan?</p>	<p>For BHRS, a separate document, identified as a crisis safety plan, is in the chart and is signed by the family and the clinician and reviewed at least monthly.</p> <p>(The crisis plan must be specific and individualized for this family and child including progressive steps to deal with the crisis)</p> <p>If a crisis occurred, there should be documentation of how stabilization was achieved.</p>

BHRS PROVIDER CHART AUDIT

<p>26. The treatment record documents preventive services, as appropriate, stress management, wellness programs, lifestyle changes, and referrals to community resources.</p>	<p>BHR Services/should document any attempts to engage parent and child in community resources.</p> <p>Documentation of the clinician’s efforts to educate the patient about approaches that might augment treatment being provided such as stress or anger management groups, wellness programs, lifestyle changes, social skills, parent support groups or community resources.</p>
<p>27. The discharge plan has been documented and updated.</p>	<p>Planning should begin on the day of admission and continues throughout treatment. Placement/living arrangements and personal support alternatives such as patient's family, significant others, other support groups should be identified in the plan.</p> <p>Discharge plan should include the criteria to be met for discharge and/or a fade plan. BHRS discharge plan should be directly related to treatment goals, individualized and specific to member.</p>
<p>28. Closed Chart/ Member’s discharge instructions are documented in the chart.</p>	<p>NA for BHRS</p>
<p>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).</p>	<p>Cultural issues identified as a presenting problem in the assessment must be included in the treatment plan.</p> <p>N/A if none are identified.</p>
<p>30. The treatment record has evidence of continuity and coordination of care between behavioral health institutions, practitioners, ancillary providers, consultants, or outpatient behavioral health treatment..</p>	<p>Progress notes should documented collaboration with school, CYS, JPO, psychiatrist, or any ancillary providers as applicable. There should be documentation of the provider’s attempts to coordinate care. Also, look for appropriate releases.</p>
<p>31. Closed Charts: A discharge summary/aftercare plan has been documented at the conclusion of treatment.</p>	<p>BHRS: A discharge summary should also include an aftercare plan addressing transition to appropriate agencies and other services. The summary should contain 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.</p>

BHRS PROVIDER CHART AUDIT

<u>Child and Adolescent Records Only – Items 32-37</u>	DEFINITIONS
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.	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. 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. N/A only if the member is over 18. Look for parent/guardian signature on the treatment plan and documentation of family involvement in the treatment notes. There must be documentation of the transfer of skills to parent/guardian/teacher/or responsible adult.
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.	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. BHRS: When services are provided in the school there must be school related treatment goals, and evidence of collaboration with school personnel
37. The record shows evidence of coordination with the youth’s school to achieve school related treatment goals.	If a child is receiving special education, a copy of the IEP must be in the medical record. (N/A if treatment goals are not related to school functioning.)
Comments:	