Outpatient Mental Health Chart 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.	Member's address, telephone number, emergency contact, and school name, as applicable.
3. Each treatment record includes the adult member's marital status, legal status, and guardianship information, if applicable.	Adult question only: a. Marital status. b. Legal status issues such as DUI, probation or pending legal action if applicable. c. Include 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.
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. **A**ll 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 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

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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.	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.
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.	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 are prescribed? b. The name of the prescriber. N/A if medications are not prescribed. There must be a documented rationale for medications changes (type, dosage).

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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. 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 If this is documented as a treatment issue, for OP it must be found in subsequent notes. 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.
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.	All 5 axes must be present.

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21.Treatment plans: 1) must be individualized 2) have measurable goals & Objectives with identification of 3) person responsible and modality used in treatment. 4) have estimated time frames for goal attainment or problem resolution .5) signed by clinician/treatment team and the member.	Tx Plan must have documentation of specific behaviors to be addressed as identified in the initial assessment and per 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.
22. The treatment plan meets timeframe standards for initial development and update/review.	Time frame standards for MH/OP Clinics: Treatment plan must be developed within 15 days of intake, reviewed and updated every 120 days or 15 patient visits whichever is first by the MHP and the psychiatrist.
23. Treatment plan goals and objectives are reflected in the progress notes.	Each progress note must contain a reference to the treatment goal being addressed during that contact.
24. There is documentation of progress or lack of progress in the treatment record.	Documentation of progress or lack of progress may be found in the progress notes, updated treatment plan, and discharge summary.
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.	NA for Outpatient level of care. .

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28. Closed Chart/ Member's discharge instructions are documented in the chart.	NA for Outpatient level 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.	Documented evidence of attempts to coordinate care. Look for appropriate releases. If dually diagnosed, check for a referral to MH or D&A.
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
Child and Adolescent Records Only – Items 32-37	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. Score N/A for D&A Charts (and MH charts for members 14 and older) if it is indicated that the child did not want active involvement of the family, legal guardians, or primary caretakers.

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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.	For MH or D&A outpatient treatment, need an assessment if applicable. 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.	Child Only NA for Adult.OP 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.)

Treatment Record-Based Adherence Indicators – Score these items if the diagnosis for any case reviewed is in the 295, 296.2, 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.89 or 314 series. Data related to these adherence indicators is used only in the aggregate – it does not enter into the total score/evaluation of the records of this individual practitioner but the results are shared with the practitioner	
Major Depression – 296.2 or 296.3 Series	DEFINITIONS
38. Mood symptoms and suicidality are assessed at every visit.	Answer this item if the diagnosis is Major Depression 296.2 or 296.3 series, Mood symptoms include: mood, affect, sleep, appetite and energy. Suicidality includes: passive suicidal thoughts, passive death wish or a suicide plan.
39. Co-morbid problems are assessed upon initial evaluation for substance abuse, medical conditions or other psychiatric diagnoses.	Axes I though IV must be completed.
40. If substance abuse is identified in the initial evaluation, a comprehensive substance abuse evaluation has been performed or recommended.	**Select N/A if substance abuse is not identified in the initial evaluation.**
41. If a substance abuse diagnosis is confirmed, then an active substance abuse treatment plan is developed or a documented referral is made for treatment.	Select N/A if substance abuse diagnosis is not confirmed.
42. Has a medication evaluation or referral taken place within 30 days of the diagnosis if not initially diagnosed by a psychiatrist?	Select N/A if initially diagnosed by a psychiatrist.
43. If medication is prescribed, there should be a minimum of three follow up visits in the first 12 weeks. (At least one of these being with the prescriber.)	Select N/A if no medication is prescribed.
44. If a secondary antidepressant is prescribed, it must be from another class of antidepressants.	Select N/A if no secondary antidepressant is prescribed.

STANDARD	
Schizophrenia – 295 Series	
45. There is evidence of an assessment of positive signs of psychosis, e.g., delusions and/or hallucinations.	
46. Co-morbid problems are assessed upon initial evaluation by the MD for substance abuse, medical conditions or other psychiatric diagnoses.	Axes I though IV must be completed.
47. Has a medication evaluation taken place within 14 days of the diagnosis if not initially diagnosed by a psychiatrist?	Select N/A if initially diagnosed by a psychiatrist.
48. When anti-psychotic medications are prescribed, there is evidence of observation for side effects including EPS such as dystonic reactions akathisia,("can't sit still"), or akinesia. {Note: this applies to all discipline levels; N/A may **not** be checked)	If there is a lack of response, or side effects to treatment with medications, then a consultation with a psychiatrist is required.

ADHD – 314.00; 314.01; 314.9	DEFINITIONS
49.The record reflects the active involvement of the family/primary caretakers in the assessment and treatment of the enrollee, unless contraindicated.	Family involvement is documented unless contraindicated. N/A if the member is over 18. Look for parent/guardian signature on the treatment plan and documentation of family involvement in the treatment notes. Select N/A if family involvement is contraindicated.
50.Co-morbid problems are assessed upon initial evaluation for substance abuse, medical conditions or other psychiatric diagnoses	Axes I though IV must be completed.
51. The record reflects education about ADHD.	If member is under 18, parent training in behavioral management. is documented.
52. Has a medication evaluation taken place within 60 days of the diagnosis if not initially diagnosed by a psychiatrist?	Select N/A if initially diagnosed by a psychiatrist
53. When medication is prescribed, there is evidence of an evaluation of the member's response to medication and adjustments as needed.	If there is a lack of response, or side effects to treatment with medications, then a consultation with a child psychiatrist or a general psychiatrist with child training or experience is recommended. (N/A if no medication is prescribed)

Bipolar Disorder – 296.0x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.89 Series	
54. Mood symptoms and suicidality are assessed at every visit.	Mood symptoms include: mood, affect, sleep, appetite and energy. Suicidality includes passive suicidal thoughts, passive death wish or a suicide plan.
55. Co-morbid problems are assessed upon initial evaluation by the MD for substance abuse, medical conditions or other psychiatric diagnoses.	Axes I though IV must be completed.
56. Has a medication evaluation taken place within 14 days of the diagnosis if not initially diagnosed by a psychiatrist?	Select N/A if initially diagnosed by a psychiatrist.

Access Standards 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: 7days
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.	Answer N/A if access standard is met. Possible reasons for not meeting standard: a. first available appointment with provider, b. member request, c. request for a specific therapist, d. not specified by provider, e. other, note in comment section.
61. List evaluator type:	List type of initial evaluation: MD, Licensed MHP, Nurse, other.
Comments:	