3B and 3C AUDIT TOOL for Drug and Alcohol
Medically Monitored Short Term and Long Term Residential

	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 member's marital status, legal status, and guardianship information, if applicable.	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 Primary Care Physician (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 and 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 clinician/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	Was the PCPC completed at admission, discharge and every 30 days while in treatment?	There must be documentation of an admission PCPC, an updated 'monthly PCPC summary' and a PCPC completed at discharge.
10	Are co-occurring psychiatric problems part of the initial assessment?	This should be noted in the history and physical or in the assessment. Can not be scored N/A

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11	Relevant medical conditions are listed, prominently identified, and revised as appropriate in the treatment record.	If a medical condition addressed on Axis 3 or *part of a PCPC* (Dimension 2) is identified as a presenting problem in the assessment, it must be addressed in the treatment plan and the progress notes *and a documented referral was made*. (including pregnancy) Can be N/A
12	Food, drug, environmental allergies and adverse reactions or no known allergies (NKA) 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. No N/A
13	There is evidence of a psychiatric evaluation when psychiatric medication is prescribed at this facility.	A completed psychiatric evaluation is required at the time of the medication prescription. (Can be N/A if not a dual facility Mental Health and SA. Or this facility is not prescribing psychotropic medication)
14	The treatment record indicates all prescribed medications, the dates prescribed, and dosages.	For 3B and 3C- Co-occurring Programs both MH and SA, this can not be N/A If the current facility has prescribed psychotropic medication all of the following elements are required: a. Medications prescribed, b. Dosages of each, c. Dates of initial prescriptions, d) prescriber For non-prescribing practitioners (outside this provider), each treatment record should indicate: a. What medications have been prescribed, b. The name of the prescriber. N/A if member is not taking any medication.
15	If medication is prescribed, there is documentation of medication education and understanding by the patient, or for a minor child, the parent/guardian.	Documentation of the risks and benefits and side effects to the patient must be documented. Can not be N/A if medication is prescribed at this facility N/A only if no medication is prescribed.
16	If prescribed medication is changed during treatment, the rationale must be documented.	There must be a documented rationale by the MD for medication changes.
17	The member's past and present history of substance use must be documented**.**	A history must document the substances most frequently used, the route, the age it was first used, the amounts used and last time the substance was used. No N/A

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18	Is there evidence of an assessment that includes a member's previous treatment, previous interventions, response to previous treatment and length of clean time?	Treatment history include interventions such as types of therapy (AA, group, individual) or levels of care such as OP, IOP, PHP, HWH, Residential, Detox, or Rehab) Can not be N/A Must be in the assessment
19	Is there evidence of an assessment of the family member's/significant other's substance use?	Include any substance abuse history within the family or significant others. Can not be N/A Must be in the assessment
20	Has the current living environment of the member been assessed?	The living environment should be documented at least at the initial assessment and at discharge. Is the current living situation stable? Is the home environment drug free? Will the member return home alone or to significant others? Can not be N/A Must be in the assessment
21	Has the current support system of the member been assessed?	The support system should be documented at least in the initial assessment and at discharge. Can not be N/A Must be in the assessment
22	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).	If cultural issues are identified in the assessment, the issues must be included in the treatment plan. N/A if none are identified.
23	A mental status exam that includes the member's affect, speech, mood, thought content, judgment, insight, attention span/concentration, memory, and impulse control is documented.	For Dual / Co-occurring 3B and 3C programs, There must be documentation of a minimum of 7 of the 9 elements for the mental status exam. (Yes or No only for Dual or co-occurring programs, can not be N/A)
24.	Special status situations, such as imminent risk of harm to self or others, are prominently noted, documented and revised in the treatment record.	For Dual/ Co-occurring 3B and 3C programs, there must be a).Evidence that the enrollee was thoroughly evaluated upon initial assessment as to dangerousness to self, to others and b). Special status situations should be addressed at each documented contact by MH and/or D&A Professional/Nurse or psychiatrist in the progress notes until special status situation is resolved.
25	A drug or alcohol diagnosis must be documented as the primary diagnosis for this level of care.	The nature of the D&A problem is clearly documented in the initial assessment, PCPC- Dimension 1 or the psychosocial This can not be N/A.

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		If using a multi axis model, the drug or alcohol diagnosis must appear on Axis I.
26	Is there documentation of a preliminary treatment plan at the beginning of treatment?	N/A if member is AMA or administratively discharged within the first 72 hrs.
27	The timeframes for development of the preliminary treatment plan and reviews are met.	The timeframe for the development of the ***preliminary*** treatment plan for 3b and 3C is ***72 hrs***. or sooner. N/A if member is AMA in the first 72 hrs. The timeframe for treatment plan ***review*** of **3B is 15 days** and treatment plan review for **3C is 30** days.
28	Treatment plans: 1) must be individualized 2) have measurable goals and objectives 3) identification of person responsible 4) modality 5) have estimated time frames for goal attainment or problem resolution 6) signed by clinician/treatment team and the member. 7). For 3B and 3C Co-occurring programs there must be separate MH and SA disorder goals.	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 with time frames to accomplish the goals Can be N/A only if member left before 72 hours
29	**3C Only** Long term Residential: At least 2 of the following have been assessed and addressed: Disordered Living Skills, Disordered Social Adaptiveness , Disordered Self Adaptiveness or Disordered Psychological Status (N/A for 3B)	Disordered living skills • Lack of socially acceptable norms and /or coping skills on an interpersonal, vocational, educational or financial management • Lack of social responsibility • Lack of emotional maturity related to use prior to adolescence Disordered Social Adaptiveness • History of antisocial behavior patterns or criminal charges • History of rebellion of acceptable parental/social values leading to a disregard of authority and basic rules Disordered Self Adaptiveness • Poor sense of self worth as evidenced by feelings of chronic rejection, loneliness or alienation

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		• Defeating and denigrating behaviors • Chronic external focus and/or seeking external stimuli to the exclusion of developing internal supports • Inability to form supportive relationships, difficulty or unwillingness to disclose feelings • Pronounced external locus of control (blaming others, unwillingness/inability to make decisions or choices to effect positive changes) Disordered Psychological Status • History of early onset (pre-adolescence) of emotional blunting or impairment or developmental disorders History of significant impulsivity without regard for potential negative consequences.
30	Treatment plan goals and objectives are clearly identified in the progress notes. For dual/co-occurring programs: • Substance abuse goals and • Mental health goals must be clearly identified in the progress notes with individual or group interventions.	For dual / co-occurring programs: there must be documentation of daily participation in a separate and distinct co-occurring program. • There must be evidence of the integration of substance abuse and mental health goals and interventions in the progress notes.
31	There should be a progress note after each "significant" client contact by staff. Documentation of progress or lack of progress toward treatment plan goals must be documented. Progress notes format to include data, assessment and plans or (strategies) relative to treatment. (DAP format) Chapter 709, Subchapter E, Standards for Inpatient Nonhospital Activities- Treatment and Rehabilitation	If group sessions are conducted, individual notes need not be written for each client. One group note will suffice(for each group) provided that it includes a comment relative to each individual's response or participation in (each) group session. For dual/ co-occurring programs, there must be integration of elements from SA and MH interventions in the progress notes such as: • Skill building interventions • MH and addiction education • Medication education • Co-occurring disorder education for individual /family

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		• Co-occurring relapse prevention Access to peer support services and self help recovery resources.
32	There must be at least one progress note for each day of the week (7/days per week)	On Saturday and Sunday, a "significant" contact by staff may include: a therapeutic group, a family visit, staff accompanied community outing, activity with staff, or treatment related activity listed on the 7-day program schedule.
33	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 such as prevention, stress or anger management, wellness program, lifestyle changes, social skills or community resources such as Narcotics Anonymous or AA.
34	Discharge planning is documented and updated during treatment.	Discharge planning should be evidenced by documentation within the first 72 hours of admission. This should be documented in the assessment and at least one other time during treatment prior to the day of discharge. Placement/living arrangements and personal support alternatives such as the patient's family, significant others, Twelve Step or other support groups, follow up such as HWH or Outpatient Therapy should be identified in the discharge plan. Include documentation of the member's declination of additional follow up services must be in the record.
35	Was this member discharged AMA or administratively?	**If Yes, answer # 36.** *If No, skip to Q # 37*
36	If #35 is yes, answer the following question: Is there evidence that any aftercare instructions were offered to the member who left AMA or administratively discharged?	Is there documentation that the member refused any aftercare?
37	Closed Chart/ Are the member's discharge/or aftercare instructions documented in the chart. (N/A for AMA, administrative discharge or an open chart)	3B and 3C Dual programs must have documented detailed (date and time) follow up appointments within 7 days for mental health and substance abuse treatment. (Closed chart)

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		Discharge/aftercare instructions should be individualized to include: a. Follow up appointments for treatment and also include a recommendation for group such as AA or NA b. Trigger identification/relapse prevention, c. Medication name, dosages, and frequency if prescribed at this site, d. Signature of the member. Discharge/aftercare instructions may also include referrals to domestic violence services or habilitative services that were addressed during treatment.
38	The treatment record has evidence of continuity and coordination of care between behavioral health and physical health institutions or, outpatient practitioners, ancillary providers, or 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. and documentation about the contacts to coordinate care.
39	Closed Charts: A discharge summary has been documented at the conclusion of treatment. May be written by the primary therapist.	(**Within 1 week after discharge) A discharge summary should include reason for treatment, services offered, response to treatment and client's status at discharge.** **Chapter 709 Subchapter E Standards for Inpatient Nonhospital Activities-Treatment and Rehabilitation)** **Other indicators may be** a. Discharge diagnosis, b. Medications, dosages and frequency if applicable, c. status of goals, d. Treatment summary, e. Barriers to treatment if applicable, f. Trigger identification/relapse prevention plan, g. Ancillary services such as NA, AA as applicable
40	What are the documented drug(s) of choice that led to this admission?	(For tracking only)
41	For transition from 3B to 3C. The Assessment must be differentiated for the levels of care. Auditor should see the distinction in documentation to substantiate the move from 3b to 3C	Discharge PCPC from higher level of care3B and/ or the admission PCPC to the lower level of care 3C should be documented in the chart. There must be a distinct episode of care documented with new goals, treatment plan, from previous 3B to substantiate continued treatment and medical necessity.