December-17

Optum Idaho - Behavioral Network Services

CASE MANAGEMENT RECORD AUDIT TOOL

Facility Name:

Reviewer Name:

Date of Facility Review:

	Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
General Documentation Standards				
1	Each client has a separate record.			
2	Each record includes the member's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
3	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.			
4	The record is clearly legible to someone other than the writer.			
5	There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the client and/or legal guardian.			
6	There is documentation that the service provider provides education to client/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.			
7	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian.			

Initial Assessment				
8	There is evidence in the record that the member is currently in active ambulatory behavioral health treatment, **OR** it is documented the member will participate in ambulatory treatment with support from case management.			
9	There is documentation of an assessment whether member needs assistance with accessing community-based services, including; housing, employment or public assistance, education, child care, transportation, or legal matters.			
10	The member has a behavioral health condition that impairs his/her functioning as described in the current comprehensive diagnostic assessment or the Global Appraisal of Individual Needs (GAIN) summary.			
11	The reasons for initiation of services are documented.			
12	A behavioral health history is in the record.			
13	A medical history and/or physical exam, along with documentation of any infectious diseases, is in the record.			
14	Was a current medical condition identified? **This is a non-scored question. (If #11 is no, then 12 is NA)**			
15	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. **This is a non-scored question.**			

16	If a medical condition was identified, there is documentation that the patient/guardian refused consent for the release of information to the treating medical clinician. **This is a non-scored question.**			
17	There is evidence an assessment was completed which determined the member was not at imminent risk of harm to self or others, and can be safely treated at this level of care.			
18	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
19	The assessment documents the spiritual variables that may impact services			
20	The assessment documents the cultural variables that may impact services			
21	An educational assessment appropriate to the age of the member and level of service is documented.			
22	There is documentation of an assessment of the member's need of assistance with accessing or utilizing ambulatory behavioral health or medical care.			
23	There is documentation of an assessment of the member's level of functioning in the domains of Activities of Daily Living.			
24	For clients 10 years and older, a screening is in evidence of use or exposure to alcohol, nicotine, and/or illicit drugs.			
25	The record documents the presence or absence of relevant legal issues of the patient and/or family.			

26	There is documentation that the patient was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.			
27	There is documentation of a screening for risk issues in the record.			
28	When risk issues are identified, there is evidence that an initial safety plan has been developed.			
Case Management Planning				
29	There is evidence that the results of the assessment are considered in the development of the case management plan.			
30	There is evidence the case manager and member collaborated to create case management plan that includes a description of member's strengths and recovery/resiliency goals.			
31	The case management plan is consistent with diagnosis and has is structured to achieve the member's stated recovery/resiliency goals.			
32	The case management plan includes focus on managing access and utilization of behavioral health or medical care, as well as managing access of peer support and other community-based supports as appropriate.			
33	There is evidence the case management plan was developed with and agreed upon with the member, and/or the member's family/social supports.			
34	There is evidence that the service plan is reviewed and updated at regular intervals.			

Progress Notes				
35	All progress notes include the date of service.			
36	All progress notes include the time of service provided.			
37	All progress notes include who is present for services.			
38	Progress notes include assessment of how the member is progressing with case management plan goals.			
39	All progress notes include who rendered services.			
40	The progress notes document on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.			
41	Progress notes include an ongoing assessment of the member's capacity to independently access services.			
42	As appropriate, progress notes document assessment of any additional services needed by the member.			
Coodination of Care				
43	Does the client have a medical physician (PCP)? **This is a non-scored question.**			
44	The record documents that the client was asked whether they have a PCP. **Y or N Only**			

45	If the client has a PCP there is documentation that communication/collaboration occurred.			
46	If the client has a PCP, there is documentation that the client/guardian refused consent for the release of information to the PCP.			
47	Is the client being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
48	The record documents that the client was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			
49	If the client is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
50	If the client is being seen by another behavioral health clinician, there is documentation that the client/guardian refused consent for the release of information to the behavioral health clinician.			
51	There is evidence in the record that, with the member's documented consent, providers and other identified services who are currently involved in the care of the member are contacted within 48 hours of initiation of services to obtain all relevant information.			
52	There is evidence in the record that, with the member's documented consent, case management is coordinated with agencies and programs, such as school, with which the member is involved.			

Discharge and Transfer

53	Was the client transferred/discharged to another clinician or program? **This is a non-scored question.**			
54	If the client was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
55	If the client was transferred/discharged to another clinician or program, there is documentation that the client/guardian refused consent for release of information to the receiving clinician/program.			
56	Prompt referrals to the appropriate level of care are documented when client cannot be safely treated at their current level of care secondary to homicidal or suicidal risk or an inability to conduct activities of daily living.			
57	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
58	The discharge/aftercare/safety plan describes specific follow up activities.			
59	There is evidence that, with member consent, all providers were notified prior to cessation of case management services to discuss the discharge plan.			
60	Clinical records are completed within 30 days following discharge.			