January-21

Optum Idaho - Behavioral Network Services

Targeted Care Coordination Record 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 member has a separate record, and all elements are available and accessible for review.			
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 Informed Consent and the PCSP OSSM Consent in the record that is signed by the member and/or legal guardian at mininum of annually or as identified by the youth/family.			
6	There is documentation that the service provider provides education to youth/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 youth and/or family or legal guardian.			

Initial Assessment				
8	There is documentation of a serious emotional disturbance or SED and the youth is under the age of 18.			
9	There is a current Children and Adolescent Needs and Strengths Assessemnt (CANS) and Comprehensive Diagnostic Assement in the record.			
10	The reasons for initiation of services are documented.			
11	A behavioral health history is in the record.			
12	A current medical history and/or results from a recent physical exam, along with documentation of any infectious diseases, is in the record.			
13	Was a current medical condition identified? **This is a non-scored question.**			
14	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. **This is a non-scored question.**			
15	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.**			
16	There is evidence an assessment was completed which determined the member is currently not at imminent risk of harm to self or others, and can be safely treated at this level of care.			

17	PCSP Plan documents considerations regarding ethnicity, faith, language, and culture.			
18	There is documentation of the need for assistance in order for the youth/family to locate, coordinate, facilitate, provide linkage, advocate for, and monitor the mental and physical health, social educational, and other services.			
19	For clients 10 years and older, a screening is in evidence of use or exposure to alcohol, nicotine, and/or illicit drugs.			
20	The record documents the presence or absence of relevant legal issues of the patient and/or family.			
21	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.			
22	There is documentation of a screening for risk issues in the record.			
23	When risk issues are identified, there is evidence that an initial safety/crisis plan has been developed and is routinely reviewed and updated.			
Person Centered Service Plan				
24	There is evidence that the results of the CANS assessment are utilized in the development of the Person Centered Service Plan.			
25	There is evidence the primary master's level clinician, with the youth/family collaborated to create the PCSP that includes a description of member's goals, strengths, needs, and natural supports.			

#	Item			
26	The goals on the PCSP are individualized to fit with the family's culture, diagnosis, and SMART (Specific, Measurable, Achievable, Realistic, and Time-Limited).			
27	The PCSP includes focus on managing, accessing, coordinating, and utilizing services and social resources that support the member in reaching their goals.			
28	There is evidence the PCSP was developed with and agreed upon with the youth/family.			
29	There is evidence that the CANS is updated every 90 days.			
30	There is evidence that the TCC coordinated and facilitated the Child and Family Team (CFT) meeting for development of the Person Centered Service Plan including documented (signature or email) confirming agreement of the PCSP by all CFT members			
31	There is evidence that the TCC coordinated and facilitated follow-up CFT meetings based on the need of the youth/family, to assess/reassess strengths and needs, and/or to update/modify plan.			
32	It is documented that the TCC in conjunction with the CFT facilitated the development of a transition plan with the youth/family to promote long-term stability including natural and community supports.			
33	It is documented that, if the member misses a CFT meeting, there is explanation why they were not able to attend (i.e. - hospitalization, illness, etc.)			
Progress Notes				
34	All progress notes include the date of service.			

35	All progress notes include the time of service provided.			
36	All progress notes include who is present for services.			
37	Progress notes include assessment of how the member is progressing with PCSP goals.			
38	All progress notes include who rendered services.			
39	The progress notes document on-going risk assessments (including but not limited to suicide and homicide) and monitoring of any at risk situations.			
40	Progress notes include an ongoing assessment of the family's ability to independently access, coordinate, and utilize services and social resources.			
41	As appropriate, progress notes document assessment of any additional services needed by the member.			
42	As appropriate, when assessment identifies additional appropriate services would be beneficial, there is evidence the member is provided with appropriate referrals.			
43	When members are provided with new referrals for services, there is evidence they were provided with reasonable options of clinicians/services to select from, or documentation (i.e. rural area) that they were educated that referral options are limited.			

#	Item			
44	There is evidence that the TCC has had contact with the member/family at least every 30 days. If TCC is unable to reach the youth/family attempts to contact are documented.			

Coodination of Care

#	Item			
45	Does the client have a medical physician (PCP)? **This is a non-scored question.**			
46	The record documents that the client was asked whether they have a PCP. **Y or N Only**			
47	If the client has a PCP there is documentation that communication/collaboration occurred.			
48	If the client has a PCP, there is documentation that the client/guardian refused consent for the release of information to the PCP.			
49	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.**			
50	The record documents that the client was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			
51	If the client is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
52	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.			

53	There is evidence of contact notes documenting interactions and coordination between service providers.			
54	There is evidence in the record that, with the youth/family's documented consent, providers and other identified services who are currently involved in the care of the member are contacted to obtain all relevant information in order to coordinate and support success.			
55	There is evidence in the record that, with the youth/family's documented consent, TCC has coordinated with other system partners (child welfare, education, juvenile probation, etc.) in order to coordinate and support success.			
Discharge and Transfer				
56	Was the client transferred/discharged to another clinician or program? **This is a non-scored question.**			
57	If the client was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
58	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.			
59	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.			
60	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			

61	The discharge/aftercare/safety plan describes specific follow up activities.			
62	There is evidence that, with member consent, all providers were notified prior to cessation of targeted care coordination services to discuss the discharge plan.			
63	Clinical records are completed within 30 days following discharge.			