December-16

UnitedHealthcare Community Plan (UHCCP)

PSYCHOSOCIAL REHAB RECORD AUDIT TOOL

Provider Name:

Reviewer Name:

Date of Review:

	Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
General Documentation Standards				
1	Each member 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 when EMR system) 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 member and/or legal guardian.			
6	There is documentation that the service provider provides education to member/family about service planning, discharge planning, supportive community services, behavioral health problems, and care options.			
7	There is documentation that the potential risks of not following treatment recommendations are discussed with the member and/or family or legal guardian.			

Initial Assessment				
8	The reasons for initiation of services are documented.			
9	A psychiatric diagnosis is included in the record.			
10	A behavioral health history is in the record.			
11	A medical history and/or physical exam, along with documentation of any infectious diseases, is in the record.			
12	Was a current medical condition identified? **This is a non-scored question. (If #11 is no, then 12 is NA)**			
13	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. **This is a non-scored question.**			
14	If a medical condition was identified, there is documentation that the member/guardian refused consent for the release of information to the treating medical clinician. **This is a non-scored question.**			
15	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
16	The assessment documents the spiritual variables that may impact services			

17	The assessment documents the cultural variables that may impact services			
18	An educational assessment appropriate to the age of the member and level of service is documented.			
19	The assessment includes evidence the member identified the skills and resources they wanted to develop.			
20	There is documentation of an assessment of the member's level of functioning in the domains of Activities of Daily Living.			
21	For members 12 years and older, a screening is in evidence of use or exposure to alcohol, nicotine, and/or illicit drugs.			
22	The record documents the presence or absence of relevant legal issues of the member and/or family.			
23	There is documentation that the member was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.			
24	There is documentation of a screening for risk issues in the record.			
25	When risk issues are identified, there is evidence that an initial safety plan has been developed.			

Service Planning

26	There is evidence that the results of the assessment are considered in the development of the service plan.			
27	The service plan is consistent with diagnosis and has BOTH objective and measurable goals. short and long term goals.			
28	The service plan is consistent with diagnosis and has BOTH short and long term goals.			
29	The service plan includes a safety plan when active risk issues are identified.			
30	There is evidence the service plan was reviewed with the member; there is evidence that the member agrees with the service plan.			
31	There is evidence that the service plan is reviewed and updated at regular intervals.			
Progress Notes				
32	All progress notes include the date of service.			
33	All progress notes include the time of service provided.			
34	Progress notes include assessment of how activities relate to the service plan goals.			
35	The progress notes describe progress or lack of progress towards service plan goals.			

36	All progress notes include who rendered services.			
37	All progress notes include ongoing monitoring of risk issues, including, but not limited to self-harm or harm to others.			
38	Progress notes include an ongoing assessment of the member's capacity to complete ADL's.			
39	As appropriate, progress notes document assessment of any additional services needed by the member.			

Coordination of Care

40	Does the member have a medical physician (PCP)? This is a non-scored question.			
41	The record documents that the member was asked whether they have a PCP. Y or N Only			
42	If the member has a PCP there is documentation that communication/collaboration occurred.			
43	If the member has a PCP, there is documentation that the member/guardian refused consent for the release of information to the PCP.			
44	Is the member being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). This is a non-scored question.			

45	The record documents that the member was asked whether they are being seen by another behavioral health clinician. Y or N Only			
46	If the member is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.			
47	If the member is being seen by another behavioral health clinician, there is documentation that the member/guardian refused consent for the release of information to the behavioral health clinician.			
Discharge and Transfer				
48	Was the member transferred/discharged to another clinician or program? **This is a non-scored question.**			
49	If the member was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.			
50	If the member was transferred/discharged to another clinician or program, there is documentation that the member/guardian refused consent for release of information to the receiving clinician/program.			
51	Prompt referrals to the appropriate level of care are documented when member 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.			
52	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
53	The discharge/aftercare/safety plan describes specific follow up activities.			

54	Clinical records are completed within 30 days following discharge.			