Jan-18

UnitedHealthcare Community Plan -- Provider Performance

Clinical Record Tool

Provider Name:

Reviewer Name:

Level of Care Reviewed:

Patient Gender:

Patient Aged

Primary Diagnosis:

Date of Review:

		Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
Comprehensive Assessment					
UnitedHealthcare Administrative Guide	**1**	A behavioral health history, including the member's response to crisis situations, previous treatment dates, identification of clinicians, therapeutic interventions and responses and sources of clinical data is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**2**	A behavioral health history including relevant family information is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**3**	An assessment of the member's current life status is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**4**	If a medical condition is identified, the medical assessment includes previous treatment dates, identification of clinicians, interventions and responses and sources of clinical data.			
Comments:					
UnitedHealthcare Administrative Guide	**5**	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. **This is a non-scored question.**			
Comments:					
UnitedHealthcare Administrative Guide	**6**	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.**			
Comments:					
UnitedHealthcare Administrative Guide	**7**	The medical assessment includes relevant family information.			
Comments:					

UnitedHealthcare Administrative Guide	**8**	A complete clinical case formulation is documented in the record (e.g., primary diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).			
Comments:					
UnitedHealthcare Administrative Guide	**9**	An initial primary treatment diagnosis is present in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**10**	Drug allergies or lack thereof and adverse reactions are clearly documented at the initial evaluation.			
Comments:					
UnitedHealthcare Administrative Guide	**11**	A complete mental status exam is in the record, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control and risk assessment (including but not limited to suicide and homicide) and monitoring of at risk situations.			
Comments:		*Applies to services rendered by a Master's level or above and only at initial intake.*			
UnitedHealthcare Administrative Guide	**12**	For patients 12 and older, a substance use assessment occurs. Documentation includes past and present use of alcohol and/or illicit drugs and nicotine, as well as prescription and over-the-counter medications.			
Comments:					
UnitedHealthcare Administrative Guide	**13**	If the assessment indicates an alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.			
Comments:					
UnitedHealthcare Administrative Guide	**14**	The substance identified as being misused was alcohol. **This is a non-scored question.**			
Comments:					
UnitedHealthcare Administrative Guide	**15**	The substance(s) identified as being misused were substance(s) other than alcohol. **This is a non-scored question.**			
Comments:					
UnitedHealthcare Administrative Guide	**16**	The substance(s) identified as being misused were alcohol and other substance(s). **This is a non-scored question.**			
Comments:					
UnitedHealthcare Administrative Guide	**17**	The substance use assessment includes a history of prior alcohol and drug treatment episodes.			
Comments:					
UnitedHealthcare Administrative Guide	**18**	For substance use disorder services, the member record includes documentation that an assessment has been conducted by an appropriately licensed individual to determine whether services can be safely provided in a medically monitored residential treatment setting.			
Comments:					
UnitedHealthcare Administrative Guide	**19**	An assessment of the member's functioning in the domain of living arrangements is in the record.			

Comments:					
UnitedHealthcare Administrative Guide	**20**	An assessment of the member's functioning in the domain of daily activities (vocational/educational) is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**21**	An assessment of the member's functioning in the domain of social support is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**22**	An assessment of the member's functioning in the domain of finances is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**23**	An assessment of the member's functioning in the domain of leisure and recreation is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**24**	An assessment of the member's functioning in the domain of physical health is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**25**	An assessment of the member's functioning in the domain of emotional and behavioral health is in the record.			
Comments:					
Coordination of Care					
UnitedHealthcare Administrative Guide	**26**	The record documents that the patient was asked whether they are being seen by a medical physician (PCP). **Y or N Only**			
Comments:					
UnitedHealthcare Administrative Guide	**27**	Does the patient have a medical physician (PCP)? **This is a non-scored question.**			
Comments:					
UnitedHealthcare Administrative Guide	**28**	If the patient has a PCP there is documentation that communication/collaboration occurred.			
Comments:					
UnitedHealthcare Administrative Guide	**29**	If the patient has a PCP, there is documentation that the patient/guardian refused consent for the release of information to the PCP.			
Comments:					
UnitedHealthcare Administrative Guide	**30**	The record documents that the patient was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			
Comments:					

UnitedHealthcare Administrative Guide	31	Is the patient being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**		
Comments:				
UnitedHealthcare Administrative Guide	32	If the patient is being seen or has been seen in the past 6 months by another behavioral health clinician, there is documentation that communication/collaboration occurred and that member/guardian consent to the release of information to the treating behavioral health clinician.		
Comments:				
UnitedHealthcare Administrative Guide	33	If the patient is being seen or has been seen in the past 6 months by another behavioral health clinician, there is documentation that the patient/guardian refused consent for the release of information to the behavioral health clinician.		
Comments:				
UnitedHealthcare Administrative Guide	34	The provider evaluates the member for other health care needs (physical health, substance abuse, or behavioral health) and refer as appropriate.		
Comments:				
UnitedHealthcare Administrative Guide	35	The record documents that the member accepted or declined the referral.		
Comments:				
UnitedHealthcare Administrative Guide	36	During the initial session, the clinician requests the member's written consent to exchange information with all appropriate treating professionals.		
Comments:				
UnitedHealthcare Administrative Guide	37	Coordination of care is completed at the time of intake.		
Comments:				
UnitedHealthcare Administrative Guide	38	Within 30 days of the initial assessment, the clinician sends the following information to other treating professionals: diagnosis, medications as prescribed, and the name of the primary clinician.		
Comments:				
UnitedHealthcare Administrative Guide	39	There is documented evidence of coordination of care throughout the course of treatment.		
Comments:				
UnitedHealthcare Administrative Guide	40	If the member's condition or medications change, an update is sent to the other treating clinicians.		
Comments:				
UnitedHealthcare Administrative Guide	41	At the completion of treatment, a copy of the termination summary is sent to the other treating clinicians.		
Comments:				
Individualized Treatment Plan and Progress Notes				

Licensure	**42**	The individualized treatment/service plan is completed within the first 30 days of admission to behavioral health services.		
Comments:				
UnitedHealthcare Administrative Guide	**43**	An assessment of the member's strengths is in the record.		
Comments:				
UnitedHealthcare Administrative Guide	**44**	An assessment of the member's personal goals is in the record.		
Comments:				
UnitedHealthcare Administrative Guide	**45**	An assessment of the member's needs is in the record.		
Comments:				
UnitedHealthcare Administrative Guide	**46**	The individualized treatment/service plan is based on member strengths.		
Comments:				
UnitedHealthcare Administrative Guide	**47**	The individualized treatment/service plan is consistent with the assessment and diagnosis.		
Comments:				
UnitedHealthcare Administrative Guide	**48**	The individualized treatment/service plan is updated every 6 months, or more frequently or as clinically indicated based on the member's progress towards goals or a significant change in psychiatric symptoms, medical condition, or community functioning.		
Comments:				
UnitedHealthcare Administrative Guide	**49**	The individualized treatment/service plan indicates that the member and/or his/her support system were involved in the development of the treatment goals as well as subsequent reviews of the treatment/service plan.		
Comments:				
UnitedHealthcare Administrative Guide	**50**	There is documentation that the member or legal guardian has agreed to the individualized treatment/service plan.		
Comments:		*For Tennessee, adolescents may give consent at age 16. However, Parents/Guardians should still be involved in the treatment planning process when applicable.*		
UnitedHealthcare Administrative Guide	**51**	The individualized treatment/service plan documents the duration and intensity of services necessary to promote the recovery and resilience of the member.		
Comments:				
UnitedHealthcare Administrative Guide	**52**	The individualized treatment/service plan identifies the problems for which the member is seeking treatment.		
Comments:				
UnitedHealthcare Administrative Guide	**53**	The individualized treatment/service plan has **measurable** objectives to address goals identified.		

Comments:				
UnitedHealthcare Administrative Guide	**54**	The individualized treatment/service plan has target dates for goal attainment.		
Comments:				
UnitedHealthcare Administrative Guide	**55**	The individualized treatment/service plan is updated whenever goals are achieved or new problems are identified.		
Comments:				
UnitedHealthcare Administrative Guide	**56**	There is at least one goal for each service being provided to the member.		
Comments:				
UnitedHealthcare Administrative Guide	**57**	The documentation supports that the member receives all care that is included on the individualized treatment/service plan.		
Comments:				
UnitedHealthcare Administrative Guide	**58**	The individualized treatment/service plan identifies staff members responsible for each objective.		
Comments:				
Licensure	**59**	The individualized treatment/service plan is signed by the staff members who developed the plan and by the primary staff members responsible for implementing the treatment/service plan.		
Comments:				
Title 33	**60**	The treatment record includes a crisis prevention/resolution plan appropriate to the current level of care. The plan includes, but is not limited to, identification of crisis triggers; steps to prevent, de-escalate, or defuse crisis situations; phone numbers of those who can assist the member, and the member's preferred treatment options in a crisis.		
UnitedHealthcare Administrative Guide	**61**	The treatment record includes discharge planning appropriate to the level of care and involving community support systems to include, for example, family, guardian, conservator, outpatient providers.		
Comments:				
UnitedHealthcare Administrative Guide	**62**	The discharge planning includes a description of the follow up treatment.		
Comments:				
UnitedHealthcare Administrative Guide	**63**	The discharge planning addresses any barriers to recovery.		
Comments:				
UnitedHealthcare Administrative Guide	**64**	The discharge planning documentation shows evidence of on-going discharge planning throughout treatment.		
Comments:				

UnitedHealthcare Administrative Guide	65	There is documentation that the member or legal guardian understands and consents to the medications used in treatment.			
Comments:					
UnitedHealthcare Administrative Guide	66	Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.			
Comments:					
QM initiative	67	When a primary care physician is identified, there is evidence that the prescriber coordinated care within 14 calendar days after initiation of a new medication. **This is a non-scored question.**			
Comments:		*If there is evidence of coordination of care outside of 14 calendar days, document how many days after initiation the coordination took place.* ***Note: this question is only applicable to non-THL providers.***			
UnitedHealthcare Administrative Guide	68	The progress notes reflect reassessments when necessary.			
Comments:					
UnitedHealthcare Administrative Guide	69	The progress notes reflect on-going risk assessments (including but not limited to suicide and homicide) and monitoring of at risk situations.			
Comments:					
UnitedHealthcare Administrative Guide	70	The progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.			
Comments:					
UnitedHealthcare Administrative Guide	71	The progress notes describe progress or lack of progress towards treatment plan goals.			
Comments:					
Licensure	72	**For Residential Treatment Only:** The member's medical record maintained for each service recipient must include the following information: a narrative summary review, at least every six months, of all medications prescribed , which includes specific reasons for continuation of each medication.			
Comments:					
Licensure	73	**For Residential Treatment Only:** A review of the Plan of Care must occur at least every thirty days after development of the Plan of Care and every thirty days thereafter and must include the following documentation: dated signature(s) of appropriate treatment staff, including physician.			
Comments:					
Licensure	74	**For Residential Treatment Only:** A review of the Plan of Care must occur at least every thirty days after development of the Plan of Care and every thirty days thereafter and must include the following documentation: an assessment of progress toward each treatment goal and/or objective with revisions as indicated.			
Comments:					
Licensure	75	**For Residential Treatment Only:** A review of the Plan of Care must occur at least every thirty days after development of the Plan of Care and every thirty days thereafter and must include the following documentation: a statement by the staff psychiatrist or physician of justification for the level of service(s) needed.			

Comments:						
Licensure	**76**	**For Residential Treatment Only:** A review of the Plan of Care must occur at least every thirty days after development of the Plan of Care and every thirty days thereafter and must include the following documentation: an assessment of suitability for treatment in a less restrictive environment.				
Comments:						
Licensure	**77**	**For Residential Treatment Only:** The member's medical record maintained for each service recipient must include the following information: written documentation of progress and changes which have occurred within the Plan of Care and, at a minimum, must be recorded daily.				
Comments:						
Continuum of Care and Disharge Planning						
UnitedHealthcare Administrative Guide	**78**	The record documents any referrals to other clinicians, services, community resources, or wellness and prevention programs.				
Comments:						
UnitedHealthcare Administrative Guide	**79**	Was the patient transferred/discharged to another clinician or program? (Y or N) **This is a non-scored question.**				
Comments:						
UnitedHealthcare Administrative Guide	**80**	If the member was transferred or discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program and that member/guardian consented for release of information to the receiving clinician/program.				
Comments:						
UnitedHealthcare Administrative Guide	**81**	If the member was transferred or discharged to another clinician or program, and there is no evidence of communication/collaboration with the receiving clinician/program, there is documentation that the member/guardian refused consent for release of information to the receiving clinician/program.				
Comments:						
UnitedHealthcare Administrative Guide	**82**	The record includes discharge summaries for psychiatric hospital or residential treatment facility admissions that occur while the member is receiving behavioral health services **or** efforts to obtain these summaries are documented.				
Comments:						
Maintenance, Confidentiality, and Access to Records						
UnitedHealthcare Administrative Guide	**83**	All entries are dated and signed (including the title of the writer) and include the responsible clinician's name, degree, license, title, and relevant identification, if applicable. Signatures may be hand written or electronic.				
Comments:						
Special Status Situations, Children and Adolescents, and Priority Populations						
UnitedHealthcare Administrative Guide	**84**	For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.				
Comments:						
Title 33, Chapter 6 Part 10	**85**	There is documentation that the member was educated about a Declaration for Mental Health Treatment.				
Comments:		*NA for acute and RTC providers*				

Title 33, Chapter 6 Part 10	**86**	There is documentation that the member was given information to develop a Declaration for Mental Health Treatment if they requested the information.		
Comments:		*NA for acute and RTC providers*		
UnitedHealthcare Administrative Guide	**87**	Each member who has executed a Declaration of Mental Health Treatment should have a copy of the form in a prominent place within their record.		
Comments:		*NA for acute and RTC providers*		
Education				
UnitedHealthcare Administrative Guide	**88**	There is documentation that the clinician provides education to patients/families about treatment planning, discharge planning, supportive community services, behavioral health problems, and care options.		
Comments:				
UnitedHealthcare Administrative Guide	**89**	When the patient is on medications, the prescribing clinician documents the patient was provided with education about the reason medication is prescribed, risks, benefits, side effects, and alternatives of each medication.		
Comments:				
UnitedHealthcare Administrative Guide	**90**	There is documentation that the risks of non-adherence with treatment recommendations are discussed with the patient.		
Comments:				
Psychiatric Inpatient Services				
Level of Care Guidelines	**91**	**For Psychiatric Inpatient Services:** The treating psychiatrist evaluates the member within 24 hours of admission.		
Comments:				
Level of Care Guidelines	**92**	**For Psychiatric Inpatient Services:** The treating psychiatrist, and when possible the member, develops a treatment plan within 24 hours of admission.		
Comments:				
Level of Care Guidelines	**93**	**For Psychiatric Inpatient Services:** The treating psychiatrist, and when possible the member, projects a discharge date within 24 hours of admission.		
Comments:				
Level of Care Guidelines	**94**	**For Psychiatric Inpatient Services:** The treating psychiatrist, and when possible the member, develops a an initial discharge plan within 24 hours of admission.		
Comments:				
Level of Care Guidelines	**95**	**For Psychiatric Inpatient Services:** If the member is a child/adolescent, the parent/guardian of the member is contacted to discuss participation in treatment and discharge planning, when such participation is essential and clinically appropriate, within 24 hours of admission.		
Comments:				
Level of Care Guidelines	**96**	**For Psychiatric Inpatient Services:** With member's documented consent, an adult member's family/social supports are contacted to discuss participation in treatment and discharge planning, when such participation is essential and clinically appropriate, within 48 hours of admission.		
Comments:				
Level of Care Guidelines	**97**	**For Psychiatric Inpatient Services:** The member's outpatient provider is contacted to obtain information about the member's presenting condition and response to treatment, within 48 hours of admission.		

Comments:				
Level of Care Guidelines	**98**	**For Psychiatric Inpatient Services:** A meeting with the parent/guardian of a child/adolescent member occurs, within 48 hours of admission, unless participation in treatment by the parent/guardian is clinically contraindicated. At least one follow-up meeting with the parent/guardian should occur prior to discharge.		
Comments:				
Level of Care Guidelines	**99**	**For Psychiatric Inpatient Services:** The treating psychiatrist provides daily documented visits with the member if edication management or the management of a co-occurring medical condition is part of the treatment plan.		
Comments:				
Residential Treatment Services				
Licensure	**100**	**For Residential Treatment Services:** Staff must document each time a service recipient self-administers medication or refuses medication. This documentation must include the date, time, medication name, and dosage. This is done for prescription and over the counter medications. This documentation must be made on the medication log sheet in the service recipient's medical record.		
Comments:				
Level of Care Guidelines	**101**	**For Residential Treatment Services:** For children and adolescents, there is evidence that the provider is actively engaging family/guardians in the treatment process (e.g. - family therapy sessions) on at least weekly basis.		
Comments:				
Level of Care Guidelines	**102**	**For Residential Treatment Services:** An evaluation is conducted by a psychiatrist within 2 days of admission followed by visits with the attending psychiatrist at least 1-2 times per week.		
Comments:				
Level of Care Guidelines	**103**	**For Residential Treatment Services:** Within the first 2 days of admission the provider and, whenever possible, the member document clear, reasonable and objective treatment and recovery goals that stem from the member's diagnosis, and are supported by specific treatment strategies which address the member's symptoms, and take into account the member's preferences and readiness for change.		
Comments:				
Level of Care Guidelines	**104**	**For Residential Treatment Services:** Provider will contact the member's outpatient provider, with the member's documented consent, within the first 2 days of admission if the member was in treatment prior to admission to obtain information about the member's presenting condition and its treatment.		
Comments:				
Level of Care Guidelines	**105**	**For Residential Treatment Services:** For children & adolescents, there is a plan to provide an adequate educational program for school-aged children and adolescents.		
Comments:				
Illness Management and Recovery				
Level of Care Guidelines	**106**	**For Illness Management and Recovery:** Group facilitator will help member to identify recovery goals that are individualized, strength based and measurable.		
Comments:				
Level of Care Guidelines	**107**	**For Illness Management and Recovery:** Group facilitator and member will collaboratively follow up on the individualized, strength based and measurable recovery goals every six months (minimum).		
Comments:				

Jan-18

UnitedHealthcare Community Plan -- Provider Performance

Clinical Record Tool - CSU

Facility Name:

Reviewer Name:

Level of Care:

Patient Gender:

Patient Age:

Primary Diagnosis:

Date of Facility Review:

		Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
Individual Plan of Care					
Licensure	**1**	An individual plan of care (IPC) is developed and agreed upon by the member, staff and family members/caregivers/ support system, as applicable, based on initial and ongoing assessment of need, designed to resolve immediate psychiatric crisis.			
Comments:					
Licensure	**2**	The IPC is completed within six (6) hours of admission.			
Comments:					
Licensure	**3**	The record includes the service recipient's name.			
Comments:					
Licensure	**4**	The record includes the date of plan development.			
Comments:					
Licensure	**5**	The record includes standardized diagnostic formulation(s) including, but not limited to the current DSM or ICD.			
Comments:					
Licensure	**6**	The record includes problems and strengths of the service recipient to be addressed.			

Comments:					
Licensure	**7**	The record includes observable and measurable individual objectives related to the specific problems identified.			
Comments:					
Licensure	**8**	The record includes interventions that address specific objectives, identify staff responsible for interventions and planned frequency.			
Comments:					
Licensure	**9**	The record includes signatures of treatment staff responsible for developing plan, including qualified prescriber.			
Comments:					
Licensure	**10**	The record includes signature of recipient (and or parent/guardian, conservator, legal custodian or attorney-in-fact). Reasons for refusal to sign and/or inability to participate in IPC development must be documented.			
Comments:					
Licensure	**11**	The record includes a projected discharge date and anticipated post discharge needs including documentation of resources needed in the community.			
Comments:					
Licensure	**12**	The record includes the status of the discharge plans, including availability of resources needed in the community, with revisions as indicated.			
Comments:					
Licensure	**13**	There is evidence the IPC is reviewed daily or upon completion of the stated goals as evidenced by documentation of dated signature(s) of appropriate treatment staff, including qualified prescriber.			
Comments:					
Licensure	**14**	There is evidence the IPC is reviewed daily or upon completion of the stated goals as evidenced by documentation of progress toward each treatment objective, with revisions as indicated.			
Comments:					
Licensure	**15**	There is evidence the IPC is reviewed daily or upon completion of the stated goals as evidenced by documentation of status of discharge plans, including availability of resources needed in the community, with revisions as needed.			
Comments:					
Licensure	**16**	There is evidence the IPC is reviewed daily or upon completion of the stated goals as evidenced by documentation of a statement by the staff psychiatrist or physician of justification for the level of service(s) needed including an assessment of suitability for treatment in a less restrictive environment.			

Comments:					
UnitedHealthcare Administrative Guide	**17**	The crisis stabilization plan identifies criteria to transition the member to a higher level of care if indicated.			
Comments:					
Individual Records					
Licensure	**18**	The individual record contains intake interview and initial physical assessment.			
Comments:					
Licensure	**19**	There is a signed and dated original consent for treatment including documentation of informed consent for the administration of medication, if applicable.			
Comments:					
Licensure	**20**	There is a report of the mental status examination and other mental health assessments, as appropriate.			
Comments:					
Licensure	**21**	Daily progress notes by the qualified prescriber, nurses and other mental health professionals, as applicable are in the record.			
Comments:					
Licensure	**22**	The record contains laboratory and radiology results, if applicable.			
Comments:					
Licensure	**23**	There is documentation of all contacts with external medical and other services.			
Comments:					
Licensure	**24**	There is original documentation of all crisis stabilization service physician medication orders.			
Comments:					
Licensure	**25**	The record contains a discharge summary with prognosis justified by explanation, documentation of discharge disposition, including aftercare arrangements, if applicable.			
Comments:					

Licensure	**26**	The record contains documentation of significant behavioral events and actions taken by staff.			
Comments:					
Licensure	**27**	Member is not kept more than 4 days without documentation of approval for extension by TDMHSA.			
Comments:					

Jan-18

UnitedHealthcare Community Plan - Behavioral Network Services

Clinical Record Tool-Psychosocial Rehabilitation

Agency/Facility/Clinician Name:

Reviewer Name:

Level of Care Reviewed:

Patient Gender:

Patient Age:

Axis I:

Axis III:

Date of Review:

Rating Scale: NA = Not Applicable Y = Yes N = No			Y	N	NA
Comprehensive Assessment					
UnitedHealthcare Administrative Guide	**1**	A behavioral health history, including the member's response to crisis situations, previous treatment dates, identification of clinicians, therapeutic interventions and responses and sources of clinical data is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**2**	A behavioral health history including relevant family information is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**3**	An assessment of the member's current life status is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**4**	If a medical condition is identified, the medical assessment includes previous treatment dates, identification of clinicians, interventions and responses and sources of clinical data.			
Comments:					
UnitedHealthcare Administrative Guide	**5**	The medical assessment includes relevant family information.			
Comments:					

UnitedHealthcare Administrative Guide	**6**	An initial primary treatment diagnosis is present in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**7**	Drug allergies or lack thereof and adverse reactions are clearly documented at the initial evaluation.			
Comments:					
UnitedHealthcare Administrative Guide	**8**	A complete mental status exam is in the record, documenting the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control and risk assessment (including but not limited to suicide and homicide) and monitoring of at risk situations. (This documentation should be included in the information requested from the referring agency.)			
Comments:					
UnitedHealthcare Administrative Guide	**9**	For patients 12 and older, a substance use assessment occurs. Documentation includes past and present use of alcohol and/or illicit drugs and nicotine, as well as prescription and over-the-counter medications.			
Comments:					
UnitedHealthcare Administrative Guide	**10**	An assessment of the member's functioning in the domain of living arrangements is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**11**	An assessment of the member's functioning in the domain of daily activities (vocational/educational) is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**12**	An assessment of the member's functioning in the domain of social support is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**13**	An assessment of the member's functioning in the domain of finances is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**14**	An assessment of the member's functioning in the domain of leisure and recreation is in the record.			

Comments:					
UnitedHealthcare Administrative Guide	**15**	An assessment of the member's functioning in the domain of physical health is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**16**	An assessment of the member's functioning in the domain of emotional and behavioral health is in the record.			
Comments:					
Coordination of Care					
UnitedHealthcare Administrative Guide	**17**	The record documents that the patient was asked whether they are being seen by a medical physician (PCP). **Y or N Only**			
Comments:					
UnitedHealthcare Administrative Guide	**18**	The patient has a medical physician (PCP). **This is a non-scored question.**			
Comments:					
UnitedHealthcare Administrative Guide	**19**	The record documents that the patient was asked whether they are being seen by another behavioral health clinician. **Y or N Only**			
Comments:					
UnitedHealthcare Administrative Guide	**20**	The patient is being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**			
Comments:					
UnitedHealthcare Administrative Guide	**21**	There is documentation of ongoing communication and coordination of care with the member's behavioral health provider.			
Comments:					
UnitedHealthcare Administrative Guide	**22**	The psychosocial rehabilitation staff evaluates the member for other health care needs (physical health, substance abuse, or behavioral health) and coordinates referrals with member's other health care providers.			
Comments:					

UnitedHealthcare Administrative Guide	**23**	The record documents that the member accepted or declined the referral.			
Comments:					
UnitedHealthcare Administrative Guide	**24**	During the initial session, the clinician requests the member's written consent to exchange information with all appropriate treating professionals.			
Comments:					
UnitedHealthcare Administrative Guide	**25**	Coordination of care is completed at the time of intake.			
Comments:					
UnitedHealthcare Administrative Guide	**26**	There is documented evidence of coordination of care throughout the course of treatment.			
Comments:					
Individual Plan of Care					
Licensure	**27**	There is a separate individual plan of care completed within the first 14 days of admission to the program.			
Comments:					
Licensure	**28**	An assessment of the member's living arrangements was completed prior to development of the individual plan of care.			
Comments:					
Licensure	**29**	An assessment of the member's vocational/educational status was completed prior to development of the individual plan of care.			
Comments:					
Licensure	**30**	An assessment of the member's social supports was completed prior to development of the individual plan of care.			
Comments:					
Licensure	**31**	An assessment of the member's financial status was completed prior to development of the individual plan of care.			

Comments:					
Licensure	**32**	An assessment of the member's basic medical history and current health information was completed prior to development of the individual plan of care.			
Comments:					
Licensure	**33**	An assessment of the member's leisure/recreational status was completed prior to development of the individual plan of care.			
Comments:					
Licensure	**34**	An assessment of the member's emotional/behavioral status was completed prior to development of the individual plan of care.			
Comments:					
Licensure	**35**	An assessment of the member's transportation was completed prior to development of the individual plan of care.			
Comments:					
Licensure	**36**	An assessment of the member's medications was completed prior to development of the individual plan of care.			
Comments:					
Licensure	**37**	An assessment of the member's history of mental health and alcohol and drug treatment episodes was completed prior to development of the individual plan of care.			
Comments:					
Licensure	**38**	The individual plan of care is based on member strengths.			
Comments:					
Licensure	**39**	The individual plan of care is consistent with the assessment of needs and goals of the member.			
Comments:					
Licensure	**40**	The individual plan of care is reviewed within 3 months of the initial development.			

Comments:					
Licensure	**41**	The individual plan of care is updated at least every 6 months.			
Comments:					
Level of Care Guidelines	**42**	The individual plan of care indicates that the member and/or his/her support system were involved in the development of the plan as well as subsequent reviews of the plan.			
Comments:					
Licensure	**43**	The individual plan of care identifies the needs and strengths of the member that are to be addressed within the particular service/program component.			
Comments:					
Licensure	**44**	The individual plan of care has specific , concrete , realistic and measurable objectives to address goals identified.			
Comments:					
Licensure	**45**	The member is making measurable gains in the specific areas identified on the individual plan of care.			
Comments:					
Licensure	**46**	The individual plan of care identifies staff members responsible for each objective.			
Comments:					
Licensure	**47**	The individual plan of care is signed by the staff members who developed the plan and by the primary staff members responsible for implementing the service plan.			
Comments:					
Title 33	**48**	The PSR record includes a crisis prevention/resolution plan appropriate to the current level of care. The plan includes, but is not limited to, identification of crisis triggers; steps to prevent, de-escalate, or defuse crisis situations; phone numbers of those who can assist the member, and the member's preferred treatment options in a crisis.			
Comments:					

UnitedHealthcare Administrative Guide	49	The discharge planning addresses any barriers to recovery.			
Comments:					
UnitedHealthcare Administrative Guide	50	The progress notes reflect reassessments when necessary.			
Comments:					
UnitedHealthcare Administrative Guide	51	The progress notes reflect on-going risk assessments (including but not limited to suicide and homicide) and monitoring of at risk situations.			
Comments:					
Level of Care Guidelines	52	Documentation reflects clinical rationale for continuation of services, updated goals and progress made in treatment, and demonstration of member's motivation and participation in treatment is.			
Comments:		Note: Services should be related to specific member individual short and long term goals.			
UnitedHealthcare Administrative Guide	53	The record documents any referrals to other clinicians, services, community resources, or wellness and prevention programs.			
Comments:					
UnitedHealthcare Administrative Guide	54	All entries are dated and signed (including the title of the writer) and include the responsible clinician's name, degree, license, title, and relevant identification, if applicable. Signatures may be hand written or electronic.			
Comments:					
UnitedHealthcare Administrative Guide	55	When appropriate there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)			
Comments:					
Education					
Title 33, Chapter 6 Part 10	56	There is documentation that the member was educated about a Declaration for Mental Health Treatment.			
Comments:					
Title 33, Chapter 6 Part 10	57	There is documentation that the member was given information to develop a Declaration for Mental Health Treatment if they requested the information.			

Comments:					
UnitedHealthcare Administrative Guide	**58**	Each member who has executed a Declaration of Mental Health Treatment should have a copy of the form in a prominent place within their record.			
Comments:					
UnitedHealthcare Administrative Guide	**59**	There is documentation that the risks of non-adherence to PSR requirements are discussed with the member.			
Comments:					

Jan-18

UnitedHealthcare Community Plan -- Provider Performance

Clinical Record Tool - Peer Support

Facility Name:

Reviewer Name:

Patient Gender:

Patient Age:

Primary Diagnosis:

Date of Facility Review:

Rating Scale: NA = Not Applicable Y = Yes N = No			Y	N	NA
Safety and Security					
UnitedHealthcare Administrative Guide	**1**	Each consumer has a separate record.			
Comments:					
UnitedHealthcare Administrative Guide	**2**	Each record includes the consumer's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
Comments:					
UnitedHealthcare Administrative Guide	**3**	All entries in the contact record include the responsible peer/family/recovery coach's name, what organization the peer works for and is dated and signed where appropriate.			
Comments:					
UnitedHealthcare Administrative Guide	**4**	The peer/family/recovery coach has the name and contact information for the consumer's psychiatrist, therapists, treatment counselor, and/or case worker in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**5**	The reasons for starting the peer services are indicated.			
Comments:					
UnitedHealthcare Administrative Guide	**6**	The goals the consumer has for working with the peer/family/recovery coach are stated in the record.			
Comments:					

UnitedHealthcare Administrative Guide	7	There is evidence in the consumer's record of an inventory of the consumer's strengths and other resilience factors such as the consumer's support network.		
Comments:				
UnitedHealthcare Administrative Guide	8	There is evidence in the consumer's record that the peer specialist conducted an inquiry as to whether the consumer has a WRAP, an advanced directive/Declaration of Mental Health, recovery plan, and a plan for managing relapse.		
Comments:				
UnitedHealthcare Administrative Guide	9	Comments on the consumer's perception on their current family and/or social supports is included in the record.		
Comments:				
UnitedHealthcare Administrative Guide	10	There is evidence in the contact record that the consumer confirms that consumer wants services.		
Comments:				
UnitedHealthcare Administrative Guide	11	There is evidence the peer specialist obtained appropriate consents to contact consumer's behavioral health clinician, medical physician, family/social supports, and/or agencies and other programs with which the consumer is involved.		
Comments:				
Coordination of Care				
UnitedHealthcare Administrative Guide	12	There is evidence in the contact record of the consumer's behavioral health clinician (e.g. psychiatrist, social worker, psychologist, counselor, treatment counselor), including contact information.		
Comments:				
UnitedHealthcare Administrative Guide	13	There is evidence in the contact record that the Peer Specialist is coordinating care with the behavioral health clinician.		
Comments:				
UnitedHealthcare Administrative Guide	14	There is evidence in the contact record that the consumer was asked whether they have a medical physician (PCP).		
Comments:				
UnitedHealthcare Administrative Guide	15	If the consumer has a PCP there is documentation that communication/collaboration occurred.		
Comments:				

Recovery Planning				
UnitedHealthcare Administrative Guide	16	There is evidence in the contact record of a recovery plan, developed by the consumer with support from the specialist as needed.		
Comments:				
UnitedHealthcare Administrative Guide	17	The recovery plan includes a description of the consumer's goals, the timeframes for meeting each goal, and the steps the consumer wants to take to achieve his/her goals.		
Comments:				
UnitedHealthcare Administrative Guide	18	The recovery plan includes a description of how the consumer will engage in peer support, empowerment activities and other community support services.		
Comments:				
UnitedHealthcare Administrative Guide	19	The recovery plan includes the development of a WRAP (if desired by the consumer) , advance directive (if desired by the consumer), and/or plan for managing relapse.		
Comments:				
UnitedHealthcare Administrative Guide	20	There is evidence that the peer/family/recovery coach has offered the consumer a range of empowerment tools.		
Comments:				
UnitedHealthcare Administrative Guide	21	The contact record shows the peer specialist is helping the consumer work with their providers.		
Comments:				
UnitedHealthcare Administrative Guide	22	There is evidence the recovery plan is reviewed at regular intervals.		
Comments:		*Review of plan should occur at least every 6 months, or more often as needed.*		
Recovery Planning				
UnitedHealthcare Administrative Guide	23	Each case note includes the date of service, start and stop time, and is signed by the Peer Specialist.		
Comments:				
UnitedHealthcare Administrative Guide	24	Each case note identifies what recovery plan goals are being addressed during the session.		

Comments:				
UnitedHealthcare Administrative Guide	**25**	The case notes reflect changes in goals as new issues are identified by the consumer.		
Comments:				
UnitedHealthcare Administrative Guide	**26**	The case notes describe/list consumer strengths and challenges and how those impact the consumer meeting or changing the recovery plan goals.		
Comments:				
UnitedHealthcare Administrative Guide	**27**	There is evidence that the peer /family/recovery coach has offered the consumer access to face to face, online or phone based support.		
Comments:				
UnitedHealthcare Administrative Guide	**28**	The peer/family/recovery coach describes in the case notes the progress or lack of progress towards recovery plan goals.		
Comments:				
UnitedHealthcare Administrative Guide	**29**	The case notes document any referrals made to other agencies, and/or support services when indicated.		
Comments:				
Transition Planning				
UnitedHealthcare Administrative Guide	**30**	If the consumer transitioned from the service, there was evidence the peer specialist coordinated the transition with the consumer's primary behavioral health clinician, and other appropriate agencies and/or supports.		
Comments:				
UnitedHealthcare Administrative Guide	**31**	If the consumer was transitioned from the service, there was evidence that the peer specialist provided the consumer with a list of appropriate peer support groups and activities.		
Comments:				
Records				
UnitedHealthcare Administrative Guide	**32**	The case notes document the date of next agreed upon appointments.		
Comments:				

UnitedHealthcare Administrative Guide **33**	The record is clearly legible to someone other than the writer.			

Comments:

Jan-18

UnitedHealthcare Community Plan - Behavioral Network Services

Clinical Record Tool - Seclusion and Restraint Psychiatric Residential Treatment Facilities

Facility Name:

Reviewer Name:

Patient Gender:

Patient Age:

Primary Diagnosis:

Date of Facility Review:

Rating Scale: NA = Not Applicable Y = Yes N = No			Y	N	NA
Protection of Residents					
Licensure	**1**	Seclusion and Restraint is used only in an emergency safety situation, which are defined as unanticipated resident behaviors which places the resident or others at a serious threat of violence or injury if no intervention occurs.			
Comments:					
Licensure	**2**	An order for seclusion and restraint is **not** written as a standing order or on an as-needed basis.			
Comments:					
Licensure	**3**	The seclusion and restraint order includes the justification for the order and the time period for the seclusion or restraint.			
Comments:					
Licensure	**4**	The use of seclusion or restraint is continuously evaluated and ended at the earliest possible time based on the assessment and evaluation of the resident's condition.			
Comments:					
Licensure	**5**	There is documentation of other interventions used prior to implementing seclusion or restraint. The documentation includes the effectiveness or ineffectiveness of the intervention.			
Comments:					
Licensure	**6**	The treatment plan addresses seclusion and restraint.			
Comments:					
Licensure	**7**	Any use of seclusion or restraint is documented in the treatment plan and reviewed by the treatment team.			
Comments:					
Licensure	**8**	The treatment plan addresses antecedents to the behavior that warrants the use of seclusion or restraint.			

Comments:					
Licensure	**9**	The treatment plan incorporates the success of previous interventions.			
Comments:					
Licensure	**10**	The resident has an individualized treatment plan in the area of seclusion or restraint. This information is communicated to all treatment team members.			
Comments:					
Licensure	**11**	The type of restraint used is consistent with the resident's behavior and physical/medical condition.			
Comments:					
Licensure	**12**	There is evidence in the record that, at the time of admission, the resident and, if applicable, their family members, were informed about the facility's seclusion and restraint policies and protocols in a language they understand.			
Comments:					
Licensure	**13**	There is a signed acknowledgment indicating an understanding of the seclusion and restraint policy in the record.			
Comments:					
Orders for Seclusion or Restraint					
Licensure	**14**	There is evidence in the record that the order for seclusion or restraint was made by a physician or other licensed practitioner permitted by the State and the facility to order seclusion or restraint.			
Comments:					
Licensure	**15**	If the resident's treating physician is available, he or she orders the seclusion or restraint.			
Comments:					
Licensure	**16**	If the order for seclusion or restraint is received verbally, it is received by a registered nurse or other licensed staff.			
Comments:					
Licensure	**17**	If the order for seclusion or restraint is received verbally, the order is verified by the physician or other licensed practitioner permitted by the State an the facility to order seclusion or restraint in a signed written form in the record within 24 hours or the order being issued.			
Comments:					
Licensure	**18**	The order for seclusion or restraint is limited to the duration of the emergency safety situation.			
Comments:					
Licensure	**19**	The order for seclusion or restraint does not exceed 4 hours for residents ages 18-21; 2 hours for residents ages 9-17; or 1 hour for residents under age 9.			

Comments:				
Licensure	**20**	There is evidence in the record that within 1 hour of the initiation of the emergency safety interventions a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face to face assessment of the physical and psychological well being of the resident including but not limited to the resident's physical and psychological status.		
Comments:				
Licensure	**21**	There is evidence in the record that within 1 hour of the initiation of the emergency safety interventions a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face to face assessment of the physical and psychological well being of the resident including but not limited to the resident's behavior.		
Comments:				
Licensure	**22**	There is evidence in the record that within 1 hour of the initiation of the emergency safety interventions a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face to face assessment of the physical and psychological well being of the resident including but not limited to the appropriateness of the intervention measures.		
Comments:				
Licensure	**23**	There is evidence in the record that within 1 hour of the initiation of the emergency safety interventions a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face to face assessment of the physical and psychological well being of the resident including but not limited to any complications resulting from the intervention.		
Comments:				
Licensure	**24**	Each order for seclusion or restraint includes the name of the ordering physician or other licensed practitioner permitted by the State and the facility to order seclusion or restraint.		
Comments:				
Licensure	**25**	Each order for seclusion or restraint includes the date and time the order was obtained.		
Comments:				
Licensure	**26**	Each order for seclusion or restraint includes the emergency safety intervention ordered and the length of time authorized for its' use.		
Comments:				
Documentation of Seclusion or Restraint				
Licensure	**27**	The documentation of the seclusion or restraint includes information about the events leading up to, during, and after the implementation of seclusion or restraint.		
Comments:				

Licensure	28	The time the emergency safety intervention actually began and ended is documented in the record.			
Comments:					
Licensure	29	The time and results of the 1 hour assessment are documented.			
Comments:					
Licensure	30	The names of all staff involved in the emergency safety intervention are documented.			
Comments:					
Licensure	31	The outcome of the emergency safety intervention is documented.			
Comments:					
Consultation with Treatment Team Physician					
Licensure	32	If the seclusion or restraint was not ordered by the treatment team physician, the physician or other licensed practitioner who ordered he seclusion or restraint should consult with the resident's treatment team physician as soon as possible to inform that physician of the emergency safety situation requiring the use of seclusion or restraint.			
Comments:					
Licensure	33	There is documentation in the record of the date and time the treatment team physician was consulted.			
Comments:					
During and Immediately After Restraint					
Licensure	34	For Restraint: There is evidence in the record that the monitoring process included assessment of the resident's mental status.			
Comments:					
Licensure	35	For Restraint: There is evidence in the record that the monitoring process included assessment of the resident's physical status (vital signs, skin integrity, circulation), including documentation of when this information cannot be obtained.			
Comments:					
Licensure	36	For Restraint: There is evidence in the record that the monitoring process included assessment of the resident's need for continued restraint.			
Comments:					
Licensure	37	For Restraint: The need for continued restraint is documented in the record.			
Comments:					
Licensure	38	For Restraint: There is evidence that, if the emergency safety situation continues beyond the time limit of the order, a licensed staff member contacts the ordering physician or other practitioner permitted by the State and the facility to order seclusion and restraint and received further instructions and/or orders.			

Comments:					
Licensure	**39**	For Restraint: The resident's response to restraint, including its' effectiveness, is documented.			
Comments:					
Licensure	**40**	For Restraint: Injuries during restraint usage are reported and documented.			
Comments:					
Licensure	**41**	For Restraint: The criteria for the use and discontinuance of restraints is documented in the record.			
Comments:					
Monitoring of the Resident During and Immediately After Seclusion					
Licensure	**42**	For Seclusion: During and immediately after seclusion, there is evidence in the record the monitoring process included assessment of the resident's psychological status.			
Comments:					
Licensure	**43**	For Seclusion: During and immediately after seclusion, there is evidence in the record the monitoring process included assessment of the resident's physical status (vital signs, skin integrity, circulation).			
Comments:					
Licensure	**44**	For Seclusion: There is evidence that, if the emergency safety situation continues beyond the time limit of the order, a licensed staff member contacts the ordering physician or other practitioner permitted by the State and the facility to order seclusion and restraint and received further instructions and/or orders.			
Comments:					
Notification of Parent(s) or Legal Guardian(s)					
Licensure	**45**	The facility notifies the parent(s) or legal guardian(s) of the resident who has been placed in seclusion or restrained as soon as possible after the initiation of each emergency safety intervention.			
Comments:					
Licensure	**46**	Documentation of this notification, including the date and time of notification and the name of the staff person providing the notification, is present in the record.			
Comments:					
Post Intervention Briefings					
Licensure	**47**	There is evidence in the record that within 24 hours after the use of seclusion or restraint, staff involved in an emergency safety intervention and the resident must have a face to face discussion to review the circumstances resulting in the use of seclusion or restraint and strategies to prevent the future use of seclusion or restraint.			
Comments:					
Licensure	**48**	Documentation of the debriefing session, including who attended, is in the record.			

Comments:					
Licensure	**49**	Changes to the resident's treatment plan resulting from the debriefing sessions are documented.			
Comments:					
Medical Treatment for Injuries Resulting from an Emergency Safety Intervention					
Licensure	**50**	The record includes documentation of all injuries received by the resident and any staff members during the emergency safety intervention.			
Comments:					
Facility Reporting					
Licensure	**51**	If the member was a minor, there was evidence in the record the facility notified the parent(s) or legal guardian(s) of any serious occurrences no later than 24 hours after the occurrence.			
Comments:					
Licensure	**52**	Documentation of the report to the State Medicaid agency and the State designated Protection and Advocacy system, including the name of the person to whom the incident was reported, is present in the record.			
Comments:					

Jan-18

UnitedHealthcare Community Plan -- Provider Performance

Clinical Record Tool - Supported Housing

Facility Name:

Reviewer Name:

Patient Gender:

Patient Age:

Primary Diagnosis:

Date of Review:

Rating Scale: NA = Not Applicable Y = Yes N = No			Y	N	NA
Comprehensive Assessment					
UnitedHealthcare Administrative Guide	**1**	A behavioral health history, including the member's response to crisis situations, previous treatment dates, identification of clinicians, therapeutic interventions and responses and sources of clinical data is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**2**	A behavioral health history including relevant family information is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**3**	An assessment of the member's current life status is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**4**	If a medical condition is identified, the medical assessment includes previous treatment dates, identification of clinicians, interventions and responses and sources of clinical data.			
Comments:					
UnitedHealthcare Administrative Guide	**5**	The medical assessment includes relevant family information.			
Comments:					
UnitedHealthcare Administrative Guide	**6**	An initial primary treatment diagnosis is present in the record.			
Comments:					

UnitedHealthcare Administrative Guide	7	Drug allergies or lack thereof and adverse reactions are clearly documented at the initial evaluation.		
Comments:				
UnitedHealthcare Administrative Guide	8	A complete mental status exam is in the record, documenting the member's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control and risk assessment (including but not limited to suicide and homicide) and monitoring of at risk situations.		
Comments:				
UnitedHealthcare Administrative Guide	9	For members 12 and older, a substance use assessment occurs. Documentation includes past and present use of alcohol and/or illicit drugs and nicotine, as well as prescription and over-the-counter medications.		
Comments:				
UnitedHealthcare Administrative Guide	10	An assessment of the member's functioning in the domain of living arrangements is in the record.		
Comments:				
UnitedHealthcare Administrative Guide	11	An assessment of the member's functioning in the domain of daily activities vocational/educational) is in the record.		
Comments:				
UnitedHealthcare Administrative Guide	12	An assessment of the member's functioning in the domain of social support is in the record.		
Comments:				
UnitedHealthcare Administrative Guide	13	An assessment of the member's functioning in the domain of finances is in the record.		
Comments:				
UnitedHealthcare Administrative Guide	14	An assessment of the member's functioning in the domain of leisure and recreation is in the record.		
Comments:				
UnitedHealthcare Administrative Guide	15	An assessment of the member's functioning in the domain of physical health is in the record.		
Comments:				

UnitedHealthcare Administrative Guide	**16**	An assessment of the member's functioning in the domain of emotional and behavioral health is in the record.		
Comments:				
Level of Care Guidelines	**17**	SH/ESH services were ordered by an independently licensed behavioral health clinician (MD, MSRN, APRN, Licensed Psychologist, LCSW, LPC, LMFT, or LSPE) for the request of the service.		
Comments:				
Coordination of Care				
UnitedHealthcare Administrative Guide	**18**	The record documents that the member was asked whether they are being seen by a medical physician (PCP). **Y or N Only**		
Comments:				
UnitedHealthcare Administrative Guide	**19**	Does the member have a medical physician (PCP)? **This is a non-scored question.**		
Comments:				
UnitedHealthcare Administrative Guide	**20**	There is documentation that communication/collaboration occurred with the PCP.		
Comments:				
UnitedHealthcare Administrative Guide	**21**	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. If there is a refusal for Coordination of Care, score as NA. **This is a non-scored question.**		
Comments:				
UnitedHealthcare Administrative Guide	**22**	The record documents that the member was asked whether they are being seen by another behavioral health clinician. **Y or N Only**		
Comments:				
UnitedHealthcare Administrative Guide	**23**	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.**		
Comments:				
UnitedHealthcare Administrative Guide	**24**	There is documentation of ongoing communication and coordination of care with the member's behavioral health provider.		
Comments:				

UnitedHealthcare Administrative Guide	25	Does the housing staff evaluate the member for other health care needs (physical health, substance abuse, or behavioral health) and coordinate referrals with member's other health care providers.		
Comments:				
UnitedHealthcare Administrative Guide	26	The record documents that the member accepted or declined the referral.		
Comments:				
UnitedHealthcare Administrative Guide	27	During the initial session, the clinician requests the member's written consent to exchange information with all appropriate treating professionals.		
Comments:				
UnitedHealthcare Administrative Guide	28	Coordination of care is completed at the time of intake.		
Comments:				
UnitedHealthcare Administrative Guide	29	There is documented evidence of coordination of care throughout the course of treatment.		
Comments:				
Level of Care Guidelines	30	There is documentation showing within 30 days of admission the provider assisted the member in obtaining a physical exam to address routine screenings and any specialty care that may be necessary.		
Comments:		*Note: Exception: members who have evidence in their SH/ESH record indicating such screening and exams occurred within the 60 days prior to admission to SH/ESH.*		
Individualized Care / Transition Plan				
Licensure	31	There is a separate, individualized transitional/housing plan completed within the first 30 days of admission to the supported housing facility.		
Comments:				
UnitedHealthcare Administrative Guide	32	The member has a housing/transition plan including interventions that are a) in conformance with the principles of recovery and/or resiliency, b) strengths based, c) measurable and have time frames for completion, and d) include detail about transition/discharge planning.		
Comments:				
Level of Care Guidelines	33	Information included in the Concurrent Review form is consistent with the documentation in the Supported Housing record and must be completed 14 days prior to the end of the current authorization period.		

Comments:					
UnitedHealthcare Administrative Guide	**34**	An assessment of the member's strengths is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**35**	An assessment of the member's personal goals is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**36**	An assessment of the member's needs is in the record.			
Comments:					
UnitedHealthcare Administrative Guide	**37**	The individualized care/transitional plan is based on member strengths.			
Comments:					
UnitedHealthcare Administrative Guide	**38**	The care/ transitional plan is consistent with the assessment of needs and goals of the member.			
Comments:					
Level of Care Guidelines	**39**	The care/ transitional plan is updated at least every 90 days as is defined in the Level of Care Guidelines for supported housing.			
Comments:					
Level of Care Guidelines	**40**	The care/transitional plan indicates that the member and/or his/her support system were involved in the development of the plan as well as subsequent reviews of the plan.			
Comments:					
UnitedHealthcare Administrative Guide	**41**	There is documentation that the member or legal guardian has agreed to the individualized care/transition plan.			
Comments:					
UnitedHealthcare Administrative Guide	**42**	The care/transition plan documents the duration and intensity of services necessary to promote the recovery and resilience of the member.			
Comments:					

UnitedHealthcare Administrative Guide	**43**	The record clearly documents the 15 hours a week training and is consistent with the targeted behaviors/goals noted on the care /transition plan.		
Comments:				
UnitedHealthcare Administrative Guide	**44**	If the member is receiving training services beyond the 15 hours a week at the facility, there is documentation of the justification of the additional services.		
Comments:				
UnitedHealthcare Administrative Guide	**45**	The care /transition plan identifies the targeted behaviors to be addressed in the supported housing setting.		
Comments:				
UnitedHealthcare Administrative Guide	**46**	The care /transition plan has specific, concrete, realistic and measurable objectives to address goals identified.		
Comments:				
UnitedHealthcare Administrative Guide	**47**	The care/transition plan has target dates for goal attainment.		
Comments:				
UnitedHealthcare Administrative Guide	**48**	The care/ transition plan is updated whenever goals are achieved or new problems are identified.		
Comments:				
UnitedHealthcare Administrative Guide	**49**	The member is making measurable gains in the specific areas identified on the care/transition plan to move to a less restrictive environment.		
Comments:				
UnitedHealthcare Administrative Guide	**50**	The care/transition plan identifies staff members responsible for each objective.		
Comments:				
Licensure	**51**	The care/transition plan is signed by the staff members who developed the plan and by the primary staff members responsible for implementing the treatment/service plan.		
Comments:				

Title 33	**52**	The treatment record includes a crisis prevention/resolution plan appropriate to the current level of care. The plan includes, but is not limited to, identification of crisis triggers; steps to prevent, de-escalate, or defuse crisis situations; phone numbers of those who can assist the member, and the member's preferred treatment options in a crisis.		
Comments:				
UnitedHealthcare Administrative Guide	**53**	The treatment record includes discharge planning appropriate to the level of care and involving community support systems to include, for example, family, guardian, conservator, outpatient providers.		
Comments:				
UnitedHealthcare Administrative Guide	**54**	The discharge planning includes a description of the follow up treatment and the anticipated housing choice for the member.		
Comments:				
UnitedHealthcare Administrative Guide	**55**	The discharge planning addresses any barriers to recovery.		
Comments:				
UnitedHealthcare Administrative Guide	**56**	The discharge planning documentation shows evidence of on-going discharge planning throughout treatment.		
Comments:				
UnitedHealthcare Administrative Guide	**57**	Staff clearly document each time a service recipient self-administers medication or refuses medication. This documentation includes the date, time, medication name, dosage and full name of staff member monitoring medication administration. This is done for prescription and over the counter medications.		
Comments:		*This documentation must be made on the medication log sheet in the service recipient's medical record.*		
UnitedHealthcare Administrative Guide	**58**	Each record includes documentation of the medications prescribed, when the member takes or refuses the medicine and the name of the staff member who observed the member taking the medication.		
Comments:				
UnitedHealthcare Administrative Guide	**59**	The progress notes include assessment of member progress with meeting treatment plan goals, including discharge.		
Comments:				
UnitedHealthcare Administrative Guide	**60**	The progress notes reflect reassessments when necessary.		
Comments:				

UnitedHealthcare Administrative Guide	61	The progress notes reflect on-going risk assessments (including but not limited to suicide and homicide) and monitoring of at risk situations.		
UnitedHealthcare Administrative Guide	62	The progress notes describe member strengths and limitations in achieving care/transition plan goals and objectives.		
Comments:				
UnitedHealthcare Administrative Guide	63	The progress notes describe progress or lack of progress toward care/ transition plan goals.		
Comments:				
Continuum of Care and Discharge				
UnitedHealthcare Administrative Guide	64	The record documents any referrals to other clinicians, services, community resources, or wellness and prevention programs.		
Comments:				
Maintenance, Confidentiality, and Access to Records				
UnitedHealthcare Administrative Guide	65	All entries are dated and signed (including the title of the writer) and include the responsible clinician's name, degree, license, title, and relevant identification, if applicable. Signatures may be hand written or electronic.		
Comments:				
UnitedHealthcare Administrative Guide	66	When appropriate there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)		
Comments:				
UnitedHealthcare Administrative Guide	67	There is a record review process to assess the content of the records for legibility, organization, completion, and conformance to documentation standards.		
Comments:				
Special Status Situations, Adolescents, and Priority Populations				
Title 33, Chapter 6 Part 10	68	There is documentation that the member was educated about a Declaration for Mental Health Treatment.		
Comments:				

Title 33, Chapter 6 Part 10	**69**	There is documentation that the member was given information to develop a Declaration for Mental Health Treatment if they requested the information.		
Comments:				
UnitedHealthcare Administrative Guide	**70**	Each member who has executed a Declaration of Mental Health Treatment should have a copy of the form in a prominent place within their record.		
Comments:				

UnitedHealthcare Community Plan - Behavioral Network Services

Clinical Record Tool - Family Support Services

Agency/Facility/Clinician Name:

Reviewer Name:

Patient Gender:

Patient Age:

Primary Diagnosis:

Date of Review:

		Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
FSS Certification Program Guidelines, Standard and Procedures	**1**	There is evidence the member with mental, emotional and/or behavioral (MEB) health disturbances has access to a comprehensive array of services that address the member's physical, emotional, social and educational needs.			
Comments:					
Level of Care Guidelines	**2**	There is evidence the member is actively participating in treatment at an ambulatory setting, or it is reasonable to expect that the member will participate in treatment with support from the CFSS staff.			
Comments:					
Level of Care Guidelines	**3**	Documentation demonstrates, within seven days of admission, providers, agencies and programs with whom the member has received treatment or been involved were contacted, with consent, to coordinate care.			
Comments:					
FSS Certification Program Guidelines, Standard and Procedures	**4**	There is evidence the services are family-driven and youth-guided.			
Comments:					
FSS Certification Program Guidelines, Standard and Procedures	**5**	There is documentation indicating the parent/guardian of the member has agreed to receive family support services.			
Comments:					

CFSS Certification Program Guidelines, Standard and Procedures	**6**	There is evidence services are child-centered, community-based and culturally and linguistically competent			
Comments:					
CFSS Certification Program Guidelines, Standard and Procedures	**7**	There is evidence treatment is guided by an individualized service plan.			
Comments:					
Level of Care Guidelines	**8**	There is evidence, the CFSS and the member/family/caregiver collaborate to formally review the individualized service plan at least every six months.			
Comments:					
Level of Care Guidelines	***9***	There are revisions to the individualized service plan made at times when there are significant changes in the member's condition, preferences, and needs.			
Comments:					
CFSS Certification Program Guidelines, Standard and Procedures	**10**	There is evidence services are delivered within the least restrictive, most normative environment that is clinically appropriate.			
Comments:					
CFSS Certification Program Guidelines, Standard and Procedures	**11**	There is evidence the CFSS provides education to caregivers regarding diagnosis, cause of disorders, treatments, and treatment adherence techniques.			
Comments:					
CFSS Certification Program Guidelines, Standard and Procedures	**12**	There is evidence the CFSS utilizes specific interventions necessary to assist caregivers in developing a Child and Family Team and in establishing and meeting the child and family's individualized goals.			
Comments:					
CFSS Certification Program Guidelines, Standard and Procedures	**13**	There is evidence the CFSS leads and models how to facilitate collaborative working relationships with providers, school staff, and other professionals.			

Comments:					
Program Guidelines, Standard and Procedures	**14**	There is evidence the CFSS teaches relevant skills needed for effective advocacy and navigation of child-serving systems (including child welfare, juvenile justice, education, mental health, and transition services).			
Comments:					
Program Guidelines, Standard and Procedures	**15**	There is evidence the CFSS assists caregivers in meeting their child's or youth's educational needs through support, education, and guidance in school related meetings (504, Individual Education Plans, etc.) and the special education system, as needed.			
Comments:					
Program Guidelines, Standard and Procedures	**16**	There is evidence the CFSS assists caregivers in identifying and connecting with services addressing substance abuse and co-occurring disorders as well as providing information and other resources, as needed.			
Comments:					
Level of Care Guidelines	**17**	There is evidence the CFSS has worked with the member/parent/caregiver to identify strengths for both the member and their family.			
Comments:					
Program Guidelines, Standard and Procedures	**18**	There is evidence the CFSS teaches the child, family, and caregiver how to identify and utilize their strengths in achieving the family's goals.			
Comments:					
Program Guidelines, Standard and Procedures	**19**	There is evidence the CFSS assists caregivers in articulating their goals and objectives for their family.			
Comments:					
Program Guidelines, Standard and Procedures	**20**	There is evidence the CFSS assists caregivers in establishing and maintaining informal and formal supports that are responsive to the unique needs of their child/family.			
Comments:					

Program Guidelines, Standard and Procedures	**21**	There is evidence the CFSS assists caregivers in learning how to access community resources and in making positive treatment choices for their child and family.			
Comments:					
Program Guidelines, Standard and Procedures	**22**	There is evidence the CFSS appropriately documents activities provided to caregivers in either their individual records or program records.			
Comments:					
Program Guidelines, Standard and Procedures	**23**	There is evidence the CFSS assists caregivers in identifying resources for specialty services such as DD/MR, adult children with special needs, medically fragile, etc. as appropriate.			
Comments:					
Program Guidelines, Standard and Procedures	**24**	Documentation indicates the CFSS serves as a caregiver support agent by providing and promoting effective family-based services (e.g. wraparound, Parents as Teachers, etc.).			
Comments:					
Program Guidelines, Standard and Procedures	**25**	Documentation indicates the CFSS serves as a caregiver support agent by assisting caregivers in obtaining services that are responsive to each family's individual needs and culture.			
Comments:					
Program Guidelines, Standard and Procedures	**26**	Documentation indicates the CFSS serves as a caregiver support agent by assisting caregivers in developing problem-solving skills to respond effectively to child and/or family crises.			
Comments:					
Program Guidelines, Standard and Procedures	**27**	Documentation indicates the CFSS serves as a caregiver support agent by fostering a sense of hope and resiliency in caregivers.			
Comments:					

FSS Certification Program Guidelines, Standard and Procedures	**28**	There is evidence the CFSS models effective coping techniques and advocacy skills.			
Comments:					
FSS Certification Program Guidelines, Standard and Procedures	**29**	There is evidence the CFSS fosters a full and equal partnership with the child, family and caregiver.			
Comments:					
Level of Care Guidelines	**30**	There is no evidence indicating the member is already receiving FSS services at the time of the request.			
Comments:					
Level of Care Guidelines	**31**	There is no indication the severity of psychosocial impairment due to a behavioral health condition requires higher intensity of intervention than can be provided through FSS services.			
Comments:					

Jan-18

UnitedHealthcare Community Plan - Behavioral Network Services

Clinical Record Tool - Supported Community Living Placement

Agency/Facility/Clinician Name:

Reviewer Name:

Patient Gender:

Patient Age:

Primary Diagnosis:

Date of Review:

Rating Scale: NA = Not Applicable Y = Yes N = No			Y	N	NA
Supported Community Living Placement (Cost Effective Alternative)					
SCL Service Expectations	**1**	The member receives support with medication adherence.			
Comments:					
SCL Service Expectations	**2**	The member receives support with making and attending appointments for Behavioral Health (BH).			
Comments:					
SCL Service Expectations	**3**	There is evidence of coordination with BH providers to ensure that treatment/interventions are available to address member's needs.			
Comments:					
SCL Service Expectations	**4**	The member receives support making and attending appointments for Medical Health.			
Comments:					
SCL Service Expectations	**5**	There is evidence of coordination with medical providers to ensure that treatment/interventions are available to address member's needs.			
Comments:					
SCL Service Expectations	**6**	The member participates in at least one off site activity each month that is encouraged by the provider and participation is facilitated by the provider (transportation, supplies, fees….).			

Comments:					
SCL Service Expectations	**7**	The member participates in at least one onsite activity each week that offers variety and is encouraged and facilitated by the provider.			
Comments:					
SCL Service Expectations	**8**	There is evidence of reviews every six (6) months.			
Comments:					
SCL Service Expectations	**9**	Weekly progress notes include documentation of how well the member is adhering to medications.			
Comments:					
SCL Service Expectations	**10**	There is documentation in the record that consistent medication non-adherence is communicated to the treating provider.			
Comments:					
SCL Service Expectations	**11**	Weekly progress notes include documentation of adherence/attendance to behavioral and physical health provider appointments as needed.			
Comments:					
SCL Service Expectations	**12**	Weekly progress notes include documentation of occurrence and result of routine home medical tests (e.g. blood sugar) as needed.			
Comments:					
SCL Service Expectations	**13**	Weekly progress notes include documentation of mental, behavioral and physical health concerns that the member is voicing as well as those concerns that staff believe need to be addressed by a provider.			
Comments:					
SCL Service Expectations	**14**	Weekly progress notes include documentation of actions staff are taking to address member/staff health concerns.			
Comments:					

SCL Service Expectations	**15**	Weekly progress notes include documentation of the member's observed behavior to include how member interacted with others.			
Comments:					
SCL Service Expectations	**16**	Weekly progress notes include documentation of activities/outings in which the member participated.			
Comments:					
SCL Service Expectations	**17**	Weekly progress notes include documentation of actions staff are taking to educate, train, and/or assist the member with their limitations (e.g. ADL deficits, lack of understanding of medications, etc.).			
Comments:					

Jan-18

UnitedHealthcare Community Plan - Behavioral Network Services

Clinical Record Tool - Applied Behavioral Analysis

Facility Name:

Reviewer Name:

Patient Gender:

Patient Age:

Primary Diagnosis:

Date of Facility Review:

		Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
General Documentation Standards					
UnitedHealthcare Administrative Guide	**1**	Each client has a separate record.			
Comments:					
UnitedHealthcare Administrative Guide	**2**	Each record includes the client's address, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
Comments:					
UnitedHealthcare Administrative Guide	**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 where appropriate.			
Comments:					
UnitedHealthcare Administrative Guide	**4**	The record is clearly legible to someone other than the writer.			
Comments:					
UnitedHealthcare Administrative Guide	**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.			
Comments:					
UnitedHealthcare Administrative Guide	**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.			
Comments:					
UnitedHealthcare Administrative Guide	**7**	There is documentation that the risks of noncompliance with treatment recommendations are discussed with the client and/or family or legal guardian.			
Comments:					
Initial Assessment					

UnitedHealthcare Administrative Guide	8	An initial primary treatment diagnosis is present in the record, including who gave the diagnosis, and any diagnostic report leading up to the ASD diagnosis.			
Comments:					
UnitedHealthcare Administrative Guide	9	There is evidence of a functional behavioral assessment in the record.			
Comments:					
UnitedHealthcare Administrative Guide	10	Prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic), are documented.			
Comments:					
UnitedHealthcare Administrative Guide	11	Each record includes a description of specific levels of behavior at baseline when establishing treatment goals.			
Comments:					
UnitedHealthcare Administrative Guide	12	For clients 12 years and older, a screening is in evidence of use or exposure to alcohol, nicotine, and/or illicit drugs.			
Comments:					
UnitedHealthcare Administrative Guide	13	In the assessment there is evidence of a screening for possible sexualized behavior.			
Comments:					
UnitedHealthcare Administrative Guide	14	The initial assessment screens for any current behavioral health conditions.			
Comments:					
UnitedHealthcare Administrative Guide	15	The behavioral health treatment history includes the following information: dates and providers of previous treatment, and therapeutic interventions and responses.			
Comments:					
UnitedHealthcare Administrative Guide	16	The initial assessment screens for any current medical conditions.			
Comments:					
UnitedHealthcare Administrative Guide	17	The medical treatment history includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses.			
Comments:					
UnitedHealthcare Administrative Guide	18	The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.			
Comments:					
UnitedHealthcare Administrative Guide	19	The record includes a thorough assessment of targeted risk behaviors which includes harm to self or others.			

Comments:					
UnitedHealthcare Administrative Guide	**20**	The record includes a history of any previous services received, for behavioral health or other intensive autism related services, including dates of service.			
Comments:					
UnitedHealthcare Administrative Guide	**21**	The behavioral health treatment history includes family history information.			
Comments:					
UnitedHealthcare Administrative Guide	**22**	The medical treatment history includes family history information.			
Comments:					
UnitedHealthcare Administrative Guide	**23**	When appropriate, there is evidence of an IEP in the record, or documentation of other school-based interventions.			
Comments:					
UnitedHealthcare Administrative Guide	**24**	The assessment documents the spiritual variables that may impact treatment			
Comments:					
UnitedHealthcare Administrative Guide	**25**	The assessment documents the cultural variables that may impact treatment			
Comments:					
UnitedHealthcare Administrative Guide	**26**	An educational assessment appropriate to the age and level of care is documented.			
Comments:					
UnitedHealthcare Administrative Guide	**27**	The record documents the presence or absence of relevant legal issues of the client and/or family.			
Comments:					
UnitedHealthcare Administrative Guide	**28**	There is documentation that the client and/or family was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.			
Comments:					
Level of Care Guidleines	**29**	Each record includes evidence of a practical focus on establishing small units of behavior which build towards larger, more significant changes in functioning related to improved health and levels of independence.			
Comments:					
Level of Care Guidleines	**30**	There is evidence of collection, quantification and analysis of direct observational data on behavioral targets during treatment and follow-up to maximize and maintain progress towards treatment goals.			
Comments:					
Level of Care Guidleines	**31**	There is evidence of efforts to design, establish, and manage the treatment environment(s) in order to minimize problem behavior(s) and maximize rate of improvement.			
Comments:					

Service Planning				
UnitedHealthcare Administrative Guide	**32**	There is evidence of the use of a carefully constructed, individualized and detailed behavior analytic treatment plan which utilizes reinforcement and other behavior analytic principles.		
Comments:				
UnitedHealthcare Administrative Guide	**33**	The service plan is consistent with diagnosis and has objective and measurable short and long term goals.		
Comments:				
UnitedHealthcare Administrative Guide	**34**	The service plan is reviewed and updated with the patient at regular intervals.		
Comments:				
UnitedHealthcare Administrative Guide	**35**	The service plan shows evidence of moving toward discharge.		
Comments:				
UnitedHealthcare Administrative Guide	**36**	There is evidence that the service plan is reviewed on a regular basis.		
Comments:				
Progress Notes				
Level of Care Guidleines	**37**	There is evidence in the progress notes of an emphasis on ongoing and frequent direct assessment, analysis, and adjustments to the treatment plan (by the Behavior Analyst) based on client progress as determined by observations and objective data analysis.		
Comments:				
Level of Care Guidleines	**38**	There is evidence in the progress notes of the use of treatment protocols that are implemented repeatedly, frequently, and consistently across environments until the client can function independently in multiple situations.		
Comments:				
UnitedHealthcare Administrative Guide	**39**	Daily notes measure patient response to intervention in specific programs		
Comments:				
UnitedHealthcare Administrative Guide	**40**	There is evidence of patient response to interventions, related to targeted behaviors.		
Comments:				
UnitedHealthcare Administrative Guide	**41**	Documentation of the Place of Service is in the service note.		
Comments:				
UnitedHealthcare Administrative Guide	**42**	It is clear in the daily notes of who rendered the services		
Comments:				

UnitedHealthcare Administrative Guide	43	The length of service (including start and stop time) is clearly documented in the service note.		
Comments:				
UnitedHealthcare Administrative Guide	44	It is clear in the service notes of the monitoring and addressing targeted risk behaviors.		
Comments:				
UnitedHealthcare Administrative Guide	45	There is evidence of notes documenting communications with parents/guardians		
Comments:				
Level of Care Guidleines	46	There is evidence of notes documenting direct support and training of family members and other involved professionals to promote optimal functioning and promote generalization and maintenance of behavioral improvements.		
Comments:				
UnitedHealthcare Administrative Guide	47	There is documentation of who is in attendance at the session (parents, other children, BCBA, etc.)		
Comments:				
UnitedHealthcare Administrative Guide	48	The record, including the service plan, reflects discharge planning.		
Comments:				
Level of Care Guidleines	49	There is evidence of regular direct observation/Supervision by a Behavior Analyst with expertise and formal training in ABA for the treatment of ASD.		
Comments:				
UnitedHealthcare Administrative Guide	50	There is evidence of specific service notes of Supervision/Direct Observation in the record.		
Comments:				
Coordination of Care				
UnitedHealthcare Administrative Guide	51	The client has a medical physician (PCP). **This is a non-scored question.**		
Comments:				
UnitedHealthcare Administrative Guide	52	The record documents that the client was asked whether they have a PCP. **Y or N Only**		
Comments:				
UnitedHealthcare Administrative Guide	53	If the client has a PCP there is documentation that communication/collaboration occurred.		
Comments:				
UnitedHealthcare Administrative Guide	54	If the client has a PCP, there is documentation that the client/guardian refused consent for the release of information to the PCP.		

Comments:				
UnitedHealthcare Administrative Guide	**55**	The client is being seen by another behavioral health clinician (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). **This is a non-scored question.**		
Comments:				
UnitedHealthcare Administrative Guide	**56**	The record documents that the client was asked whether they are being seen by another behavioral health clinician. **Y or N Only**		
Comments:				
UnitedHealthcare Administrative Guide	**57**	If the client is being seen by another behavioral health clinician, there is documentation that communication/collaboration occurred.		
Comments:				
UnitedHealthcare Administrative Guide	**58**	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.		
Comments:				
Discharge and Transfer				
UnitedHealthcare Administrative Guide	**59**	The client was transferred/discharged to another clinician or program. **This is a non-scored question.**		
Comments:				
UnitedHealthcare Administrative Guide	**60**	If the client was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.		
Comments:				
UnitedHealthcare Administrative Guide	**61**	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.		
Comments:				
UnitedHealthcare Administrative Guide	**62**	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.		
Comments:				
UnitedHealthcare Administrative Guide	**63**	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.		
Comments:				
UnitedHealthcare Administrative Guide	**64**	The discharge/aftercare/safety plan describes specific follow up activities.		
Comments:				
UnitedHealthcare Administrative Guide	**65**	Clinical records are completed within 30 days following discharge.		
Comments:				

Jan-18

UnitedHealthcare Community Plan - Behavioral Network Services

Clinical Record Tool - Systems of Support

Agency / Facility / Clinician Name:

Reviewer Name:

Patient Gender:

Patient Age:

Primary Diagnosis:

Date of Review:

	Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
1	The initial interview and comprehensive assessment were completed within the appropriate timeframe.			
Comments:				
2	The relationship map and member lifeline were completed within the appropriate timeframe.			
Comments:				
3	The Cross System Crisis Plan was completed within the appropriate timeframe.			
Comments:				
4	The Cross System Crisis Plan is individualized.			
Comments:				
5	The member and caregiver were trained regarding the cross system crisis plan at initial visit.			
Comments:				
6	The SOS team meeting occurred within 7 days of initial visit			

Comments:				
7	There is evidence of a comprehensive review of any current or history of health care issues.			
Comments:				
8	There is evidence of a comprehensive review of any current or history of behavioral health issues.			
Comments:				
9	The initial review includes an assessment of medical, behavioral health, or emotional concerns and how they could trigger the need for behavioral and/or crisis intervention.			
Comments:				
10	The record of care includes documentation of all medications the member is currently taking, including those which could impact behaviors.			
Comments:				
11	The record of care includes documentation of medications prescribed to address behavioral needs.			
Comments:				
12	The record includes documentation of family members, friends, other service providers, or others instrumental in planning and implementing behavioral supports.			
Comments:				
13	The record includes documentation of member's SOS team including the SOS Champion, SOS Liaison, PCP and other service providers.			
Comments:				
14	There is evidence that the SOS Coordinator met face-to face and telephonically to adhere to member and SOS team contact frequency guidelines.			
Comments:				

15	There is evidence of development of community linkages and cross-system supports based on the individualized needs of each member and in accordance with the member's CPIP.			
Comments:				
16	There is evidence of training by the SOS provider for paid and unpaid caregivers to equip them to provide positive behavior supports to effectively manage day-to-day situations and environments in positive ways that do not result in behavioral health crises and quickly identify and address potential behavioral health crisis situations, intervening immediately to de-escalate a potential behavioral health crisis situation whenever possible.			
Comments:				
17	For individuals enrolled in an HCBS waiver or ECF CHOICES, the Plan of Support will be incorporated into the ISP/PCSP in order to ensure integration/coordination of behavior support needs across the services and setting.			
Comments:				
18	The **Plan of Support** is updated on a regular basis, including any time the member requires crisis intervention which warrants a change to the Plan.			
Comments:				
19	There is evidence that there is ongoing review and revision by the SOS provider as needed of the **Crisis Prevention and Intervention Plan**, including any time there is a crisis event resulting in the need for intervention and stabilization services or upon request of the paid or unpaid caregivers which meet the standards in the medical necessity criteria.			
Comments:				
21	The record documents that the member was asked whether they have a PCP. Y or N Only			
Comments:				
22	If the member has a PCP there is documentation that communication/collaboration occurred.			
Comments:				
23	If the member has a PCP, there is documentation that the member/guardian refused consent for the release of information to the PCP.			
Comments:				

24	The member is receiving any behavioral health services from another behavioral health clinician (e.g., psychiatrist, social worker, psychologist and substance abuse counselor).			
Comments:				
25	The record documents that the member was asked whether they are receiving services from behavioral health clinicians/providers. **Y or N Only**			
Comments:				
26	If the member is receiving services by behavioral health providers, there is documentation that communication/collaboration occurred.			
Comments:				
27	If the member is receiving services from behavioral health providers, there is documentation that the member/guardian refused consent for the release of information to the behavioral health providers.			
Comments:				
28	Each activity rendered as part of the overall crisis prevention, intervention and stabilization service is documented in the member's record.			
Comments:				
29	The date and time of service rendered is included in the service note.			
Comments:				
30	There is documentation of the reason the service was rendered in the service note.			
Comments:				
31	There is documentation of the type of intervention or service rendered in the service note.			
Comments:				
32	There is documentation of all individuals present in the service note.			
Comments:				

33	There is documentation of the name and credentials of the provider who delivered the service in the member's record.			
Comments:				
34	When applicable, there is documentation of any changes made to any behavior support plan in the service note.			
Comments:				
35	There is documentation in the record of SOS team meetings being held.			
Comments:				
36	If all SOS team members are not able to participate in each SOS team meeting, there is documentation of communication with all SOS team members.			
Comments:				
37	If the person was discharged/transferred to another service, there is evidence of this in the record.			
Comments:				
38	If the person was discharged/transferred to another service, there is evidence of coordination or communication with the new service provider.			
Comments:				
39	If the person was discharged/transferred to another service, there is evidence of coordination with the residential provider ISC, and family caregivers as applicable.			
Comments:				
40	If the person was discharged/transferred to another service, there is evidence of training for paid and unpaid caregivers on any adjustments to the Crisis Prevention and Intervention Plan.			
Comments:				
41	If the person was discharged/transferred to another service, there is evidence of training updates on the System of Support as needed.			
Comments:				
42	If the person was discharged/transferred to another service, evidence that the discharge/transfer is reflected in the provider's analytics and dashboard elements.			
Comments:				

	43	If the SOS provider initiated termination of the service, there is documentation of a Provider Initiated Notice submitted timely to UHCCP and the Grier letter shared with the member prior to discharge.			
Comments:					
	44	The RAND 36 was completed at intake and discharge (if applicable).			
Comments:					

		Since enrollment in SOS has the member:	Y	N
		Been Hospitalized		
		Been Incarcerated		
		Received Mobile Crisis Services		
		Received Behavioral Respite Services		
		Received Emergency Room Services		
		Are there any outcomes evidenced:	Y	N
		Community engagement		
		Self-managed medications		
		Meaningful participation		
		Funding eligibility		
		Personal Health Management		
		Member social contact		
		Recovery Support participation		
		Sobriety		
		Personal financial management		
		Transportation support		
		Personal living space management		
		Use of personal technology		
		Successful graduation		