Behavioral Health Provider Audit Tool Elements	
General Requirements	Yes, No, N/A
The record is accurate and clearly legible to someone other than the writer.	
Each page of record identifies the member.	
All entries in the record include the responsible service provider's name.	
All entries in the record include the responsible service provider's professional degree and relevant identification number, if applicable.	
All entries in the record include date where appropriate.	
All entries in the record include signature (including electronic signature for EMR systems) where appropriate.	
Each record includes member's address.	
Each record includes employer and/or school address and telephone number, if applicable.	
Each record includes home and/or work telephone numbers.	
Each record includes emergency contact information.	
Each record includes date of birth.	
Each record includes gender.	
Each record includes relationship and/or legal status, if applicable.	
For members 0 to 18, documentation of guardianship is included in the record, and proof of guardianship, if applicable.	
For members 0 to 18, there is evidence that services are in context of the family.	
For members 0 to 18, there is evidence of ongoing communication with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.	
For members 0 to 18, there is evidence of ongoing coordination with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.	
Each member has a separate record.	
For telemedicine/telehealth services, there is evidence in the record of verification of recipient’s identity.	

For telemedicine/telehealth services, when possible (i.e. at the next in person treatment planning meeting), providers must have the recipients sign all documents that had verbal agreements previously documented.	

Member Rights	Yes, No, N/A
There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the member and/or legal guardian.	
The Patient Bill of Rights is either signed or refusal is documented.	
There is evidence of the member being given information regarding member's rights to confidentiality.	
For members over the age of 18 years of age, the member is given information to create psychiatric advance directives or refusal is documented.	
If utilizing telemedicine/telehealth services, the consent form includes the rationale for using telemedicine/telehealth in place of in-person services	
If utilizing telemedicine/telehealth services, the consent form includes the risks of telemedicine/telehealth, including privacy related risks.	
If utilizing telemedicine/telehealth services, the consent form includes the benefits of telemedicine/telehealth, including privacy related risks.	
If utilizing telemedicine/telehealth services, the consent form includes possible treatment alternatives.	
If utilizing telemedicine/telehealth services, the consent form includes risks of possible treatment alternatives.	
If utilizing telemedicine/telehealth services, the consent form includes benefits of possible treatment alternatives.	
If utilizing telemedicine/telehealth services, the consent form includes the risks and benefits of no treatment	
For telemedicine/telehealth services, there is consent signed by the recipient or authorized representative in the record authorizing recording of the session.	

For telemedicine/telehealth services, providers need the consent of the recipient and/or the recipient's parent or legal guardian (and their contact information) prior to initiating a telemedicine/telehealth service with the recipient if the recipient is 18 years old or under.	

Treatment Plan	Yes, No, N/A
The treatment plan is in the record.	
Treatment plan is signed by the member.	
Treatment plan is signed by member's guardian, if applicable.	
Treatment plan signed by treating LMHP including credentials in signature.	
Treatment plan signed by caregiver or other treating professionals or paraprofessionals involved in tx team.	
Date of treatment plan.	
Indication if it is an "initial" or an "updated" treatment plan.	
Member signature with a statement that they participated in the treatment plan development and agree to participate in the care/treatment with member signature date.	
The treatment plan is updated whenever goals are achieved, or new problems are identified.	
Progress on all goals are included in the update.	
Treatment plan is based on the assessment (initial or updated).	
Member's strengths are included in the treatment plan.	
Member's needs are included in the treatment plan.	
Treatment plan utilizes input from the member, family, natural supports, and/or treatment team.	
Treatment plan is developed by an LMHP.	
Treatment plan is consistent with diagnosis.	
Treatment plan has long term goals.	
Treatment plan has short term goals/objectives/interventions.	
Treatment plan goals/objectives/interventions are specific.	
Treatment plan goals/objectives/interventions are measurable.	
Treatment plan goals/objectives/interventions are action oriented.	
Treatment plan goals/objectives/interventions are realistic.	
Treatment plan goals/objectives/interventions are time limited.	
There is evidence the treatment has been revised/updated to meet the changing needs of the member, if applicable.	

Treatment plan reflects services to be provided in the amount.	
Treatment plan reflects services to be provided in the type.	
Treatment plan reflects services to be provided in the duration.	
Treatment plan reflects services to be provided in the frequency.	
Individualized Crisis Plan is in the record, including any changes related to COVID-19 risks.	
Member signature with a statement that they participated in the crisis plan development.	
Crisis plan is updated as needed to meet participant's needs.	
For telemedicine/telehealth services, there is evidence in the record of a back-up plan (e.g., phone number where recipient can be reached) to restart the session or to reschedule it, in the event of technical problems.	
For telemedicine/telehealth services, there is evidence in the record of a a safety plan that includes at least one emergency contact and the closest ER location, in the event of a crisis.	
Agency Specific Requirements	
Mental Health Rehabilitation	
Treatment plan has recovery focused goals targeting areas of risk identified in the assessment.	
Treatment plan has recovery focused objectives/interventions targeting areas of risk identified in the assessment.	
Treatment plan has recovery focused goals targeting areas of need identified in the assessment.	
Treatment plan has recovery focused objectives/interventions targeting areas of need identified in the assessment.	
Treatment plan clearly identifies actions to be taken by provider.	
Treatment plan clearly identifies actions to be taken by member/guardians.	
Treatment plan clearly identifies specific interventions that will address specific problems/needs identified in the assessment.	
Transition plan describes how member will transition from adolescence to adulthood in the record for members ages 15 to 21.	
The treatment plan review is in consultation with provider staff at least once every 180 days or more often if indicated.	
The treatment plan review is in consultation with the member/caregiver at least once every 180 days or more often if indicated.	

The treatment plan review is in consultation with other stakeholders at least once every 180 days or more often if indicated.	
Documentation of the treatment plan review.	
Evidence the member received a copy of the plan upon completion.	
PRTF	
The plan must be developed no later than 72 hours after admission	
The plan must be implemented no later than 72 hours after admission	
The plan must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to determine that services being provided are or were required on an inpatient basis	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to recommend changes in the plan, as indicated by the member's overall adjustment as an inpatient.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of therapies designed to meet the objectives.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of activities designed to meet the objectives.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of experiences designed to meet the objectives.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, post-discharge plans.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, coordination of inpatient services, with partial discharge plans.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's family upon discharge.	
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's school upon discharge.	

The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's community upon discharge.	
TGH	
There is evidence of a standardized assessment and treatment planning tool such as the CALOCUS/CANS being utilized for treatment planning.	
Member's plan of care was developed no later than 72 hours after admission unless clinical documentation notes member's refusal or unavailability.	
The treatment plan must include behaviorally measurable discharge goals.	
SUD General Requirements	
Treatment plans are based on evaluations.	
Treatment plans include person centered goals.	
Treatment plans include person centered objectives.	
Treatment plan shall include other medical/remedial services intended to reduce the identified condition.	
The treatment plan should include anticipated outcomes of the individual.	
Treatment plans should include a referral to self-help groups (AA/NA, Al-Anon).	
The treatment plan specifies the frequency.	
The treatment plan specifies the amount.	
The treatment plan specifies the duration.	
The treatment plan is signed by the LMHP or physician responsible.	
Treatment plan specifies a timeline for re-evaluation of that plan (not to exceed 1 year).	
Treatment plans re-evaluations involve the individual.	
Treatment plan re-evaluations involve the family, if available.	
Treatment plan re-evaluations involve the provider.	
Re-evaluations determine if services have contributed to meeting the stated goals.	
If no measurable reduction has occurred, a new treatment plan will be developed.	
If a new treatment plan is developed it includes a different rehabilitation strategy.	
If a new treatment plan is developed it includes revised goals.	

If the services are being provided to a youth enrolled in a wrap-around agency, the substance abuse provider must be on the Child and Family Team or working closely with the CFT.	
ASAM Level Specific Requirements	
ASAM Level 1	
The treatment plan is reviewed/updated in collaboration with the member, as needed, at a minimum of every 90 days or more frequently if indicated by the member's needs.	
ASAM Level 2-WM	
The treatment plan is reviewed and signed by the physician within 24 hours of admission.	
The treatment plan is reviewed and signed by the individual within 24 hours of admission or documentation of why not.	
Treatment plan is updated at least every 30 days.	
ASAM Level 2.1	
The treatment plan is reviewed/updated in collaboration with the member, as needed, or at minimum of every 30 days or more frequently if indicated by the member's needs.	
ASAM Level 3.1 Adult/Adolescent	
Initial treatment plan completed with collaboration of the member within 72 hours of admission or documentation of why not.	
Treatment plan updates every 90 days or as indicated by member needs.	
ASAM Level 3.2-WM Adult/Adolescent	
The treatment plan is developed in collaboration with the member within 24 hours or documentation of why not.	
The treatment plan is reviewed and signed by the qualified professional within 24 hours of admission.	
The treatment plan is reviewed and signed by the individual within 24 hours of admission.	
The signed treatment plan must be filed in the individual's record within 24 hours of admission.	
ASAM Level 3.3	
Initial treatment plan completed with collaboration of the member within 72 hours of admission or documentation of why not.	
Treatment plan updates every 90 days or as indicated by member needs.	

ASAM Level 3.5 Adult/Adolescent	
Initial treatment plan completed with collaboration of the member within 72 hours of admission or documentation of why not.	
Treatment plan updates every 30 days or as indicated by member needs.	
There is evidence in the record of an in-house education/vocational component if serving adolescents.	
ASAM Level 3.7-WM	
A qualified professional creates a plan of action until individual is physically stable.	
The treatment plan is reviewed by physician within 24 hours of admission as evidenced by date and signature.	
The treatment plan is reviewed by the individual within 24 hours of admission as evidenced by date and signature or documentation of why not.	
The signed treatment plan is filed in the individual's record within 24 hours of admission.	
ASAM 3.7 Adolescent PRTF	
The treatment plan is reviewed/updated in collaboration with the member, as needed, or at a minimum of every 30 days.	
ASAM Level 3.7 Adult	
Initial treatment plan completed with collaboration of the member within 72 hours of admission or documentation of why not.	
Treatment plan updates every 30 days or as indicated by member needs.	
ASAM Level 4-WM	
The treatment plan is reviewed by physician within 24 hours of admission as evidenced by date and signature.	
The treatment plan is reviewed by the individual within 24 hours of admission as evidenced by date and signature or documentation of why not.	
The signed treatment plan is filed in the individual's record within 24 hours of admission.	

Progress Notes	Yes, No, N/A
Progress notes reference treatment goals.	
All progress notes document clearly who is in attendance during each session (outpatient services).	
The progress notes describe progress or lack of progress towards treatment plan goals.	
The progress notes describe/list member strengths.	
The progress notes describe/list how strengths impact treatment.	
The progress notes describe/list limitations.	
The progress notes describe/list how limitations impact treatment.	
The progress notes document continuous substance use assessment (if applicable).	
The progress notes document on-going risk assessments (including but not limited to suicide and homicide).	
The progress notes document (including but not limited to suicide and homicide) monitoring of any at risk situations.	
Compliance or non-compliance with medications is documented (if applicable).	
Indication of ongoing discussion of discharge planning to alternative or appropriate level of care.	
Progress notes include date of service noted.	
Progress notes include begin times of service noted.	
Progress notes include end times of service noted.	
Progress notes include signature of the person making the entry. If initials are utilized, initials of providers must be identified with correlating signatures.	
Progress notes include the functional title, applicable educational degree and/or professional license of the person making the entry.	
The progress notes document the dates or time periods of follow up appointments.	
Provider documents when the member misses' appointments, if applicable.	
When appropriate there is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken.)	
Progress notes document specifically if service was provided through Telemedicine/Telehealth. (outpatient services)	
All progress notes include documentation of the billing code that was submitted for the session.	

Services documented in the progress note reflect services billed.	
The progress notes reflect reassessments, if applicable.	
There is evidence of progress summaries in the record.	
There is evidence of progress summaries completed at least every 90 days, or more frequently as needed, if applicable.	
Progress summaries document the start and end date for the time period summarized.	
Progress summaries indicate who participated.	
Progress summaries indicate where contact occurred.	
Progress summaries indicate what activities occurred.	
Progress summaries indicate how the recipient is progressing or lack of progression toward the personal outcomes in the treatment plan.	
Progress summaries document any deviation from the treatment plan, if applicable.	
Progress summaries document any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and/or treatment plan change, as applicable.	
Progress summaries include signature of the person completing the summary. If initials are utilized, initials of providers must be identified with correlating signatures.	
Progress summaries include the functional title, applicable educational degree and/or professional license of the person completing the summary.	
Progress summaries are dated.	
Progress summaries shall be signed by the person providing the services.	
For telemedicine/telehealth services, there is evidence in the record the member was informed of all persons who are present.	
For telemedicine/telehealth services, there is evidence in the record the member was informed of the role of each person.	
For telemedicine/telehealth services, evidence in the record that, regardless of the originating site, providers must maintain adequate medical documentation to support reimbursement of the visit.	
For telemedicine/telehealth services, documentation if recipient refused services delivered through telehealth.	
Agency Specific Requirements	
Mental Health Rehabilitation	
Services are provided at the provider agency, in the community, in the member's place of residence, and/or via telehealth/telemedicine as outlined in the treatment plan.	

Services may be furnished in a nursing facility only in accordance with policies and procedures issued by the Department. Services shall not be provided in an IMD, if applicable.	
Services are documented as being provided individually or in a group setting.	
Services are documented as being provided face-to-face and/or via telehealth as per LDH guidelines.	
Services are appropriate for age.	
Services are appropriate for development level.	
Services are appropriate for education level.	
Services must be directed exclusively toward the treatment of the Medicaid-eligible individual and not be provided at a work site which is job tasks-oriented and not directly related to the treatment of the member's needs.	
Services must be directed exclusively toward the treatment of the Medicaid-eligible individual and must not contain Service or service components in which the basic nature is to supplant housekeeping, homemaking or other basic services for the convenience of the individual receiving services.	
Progress notes for PSR services document restoration, rehabilitation and/or support to develop social and interpersonal skills to increase community tenure in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	
Progress notes for PSR services document restoration, rehabilitation and/or support to enhance personal relationships in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	
Progress notes for PSR services document restoration, rehabilitation and/or support to establish support networks in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	
Progress notes for PSR services document restoration, rehabilitation and/or support to increase community awareness in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	
Progress notes for PSR services document restoration, rehabilitation and/or support to develop coping strategies and/or effective functioning in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	

Progress notes for PSR services document restoration, rehabilitation and/or support to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living in accordance with the treatment plan.	
PSR progress notes for PSR services document implementing learned skills to assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairment in accordance with the treatment plan.	
Progress notes for CPST services document problem behavior analysis in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document emotional and behavioral management in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document developing and improving daily functional living skills in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document implementing social, interpersonal, self-care, and independent living skill goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document implementing interpersonal goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document implementing self-care goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
Progress notes for CPST services document implementing independent living skill goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	
ASAM Requirements Level 2-WM, 3.7-WM, 4-WM	
Progress notes document the implementation of the stabilization/treatment plan.	
Progress notes document the individual's response to and/or participation in scheduled activities.	
Progress notes document the individual's physical condition.	

Progress notes document the individual's vital signs.	
Progress notes document the individual's mood.	
Progress notes document the individual's behavior.	
Progress notes document statements about the individual's condition.	
Progress notes document statements about the individual's needs.	
Progress notes document Information about the individual's progress or lack of progress in relation to stabilization/treatment goals.	
ASAM Requirements Level 2.1	
Progress notes include documentation of evidence-informed practices, such as cognitive behavioral therapy (CBT), motivational interviewing and/or multidimensional family therapy.	
ASAM Requirements Level 3.2-WM	
Progress notes document the implementation of the stabilization/treatment plan.	
Progress notes document the individual's response to and/or participation in scheduled activities.	
Progress notes document the individual's physical condition.	
Progress notes document the individual's vital signs.	
Progress notes document the individual's mood.	
Progress notes document the individual's behavior.	
Progress notes document statements about the individual's condition.	
Progress notes document statements about the individual's needs.	
Progress notes document Information about the individual's progress or lack of progress in relation to stabilization/treatment goals.	
Daily assessment of progress through withdrawal management shall be documented in a manner that is person-centered.	
Daily assessment of progress through withdrawal management shall be documented in a manner that is individualized.	

Continuity and Coordination of Care	Yes, No, N/A
The record documents that the member was asked whether they have a PCP.	
PCP's name is documented in the record, if applicable.	
PCP's address is documented in the record, if applicable.	
PCP's phone number is documented in the record, if applicable.	

If the member has a PCP, there is evidence of provider attempting or successfully communicating with PCP or there is documentation that the member/guardian refused consent for the release of information to the PCP.	
The record documents that the member was asked whether they are being seen by another behavioral health clinician.	
Other behavioral health clinician's name is documented in the record, if applicable.	
Other behavioral health clinician's address is documented in the record, if applicable.	
Other behavioral health clinician's phone number is documented in the record, if applicable.	
If the member is being seen by another behavioral health clinician, there is documentation that the member/guardian refused or granted consent for the release of information to the behavioral health clinician.	
Provider documents any referrals made to other clinicians, agencies, and/or therapeutic services, if applicable.	
Release of Information signed, or refusal noted for communications with other treating providers, if applicable.	
SUD	
Documentation of coordination with other child-serving systems should occur, as needed, to achieve the treatment goals.	
SUD ASAM Level 2-WM	
Evidence of ambulatory withdrawal management [ASAM level 2-WM] is provided in conjunction with ASAM level 2.1 intensive outpatient treatment services.	

Medication Management (if applicable)	Yes, No, N/A
Each record indicates what medications have been prescribed.	
Each record indicates the dosages of each medication.	
Each record indicates the dates of initial prescription or refills.	
Documentation of member education of prescribed medication including benefits.	
Documentation of member education of prescribed medication including risks.	
Documentation of member education of prescribed medication including side effects.	

Documentation of member education of prescribed medication including alternatives of each medication.	
For members 18 and over, documentation of the member understanding and consenting to the medication used in treatment.	
For children and adolescent's documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.	
Documentation that a query was done through the Prescription Monitoring Program (PMP) for behavioral health patients for controlled substances or otherwise applicable.	
AIMS (Abnormal Involuntary Movement Scale) performed when appropriate (e.g., member is being treated with antipsychotic medication).	
Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs and chronic conditions to document ongoing monitoring.	
There is evidence that lab work is ordered, if applicable.	
There is evidence the ordered lab work is received by the clinician ordering the lab work, if applicable.	
There is evidence ordered lab work has been reviewed by the clinician ordering the lab work, if applicable as evidenced by date and signature of clinician.	
When a primary care physician is identified, there is evidence the prescriber attempted coordination of care within 14 calendar days after initiation of a new medication.	
There is evidence of medication monitoring in the treatment record, documenting adherence.	
There is evidence of medication monitoring in the treatment record, documenting efficacy.	
There is evidence of medication monitoring in the treatment record, documenting adverse effects.	
TGH	
Psychotropic medications should be used with specific target symptoms identification.	
Psychotropic medications should be used with medical monitoring.	
Psychotropic medications should be used with 24-hour medical availability when appropriate and relevant.	

SUD (All ASAM Levels)	
There is evidence that the member was assessed to determine if Medication Assisted Treatment (MAT) was a viable option of care, based on the Substance Use Disorder (SUD) diagnosis.	
SUD providers, when clinically appropriate, shall educate members on the proven effectiveness of Food and Drug Administration approved MAT options for their SUD.	
SUD providers, when clinically appropriate, shall educate members on the proven benefits of Food and Drug Administration approved MAT options for their SUD.	
SUD providers, when clinically appropriate, shall educate members on the proven risks of Food and Drug Administration approved MAT options for their SUD.	
SUD providers, when clinically appropriate, shall Provide on-site MAT or refer to MAT offsite.	
SUD providers, when clinically appropriate, shall document member education in the progress notes.	
SUD providers, when clinically appropriate, shall document access to MAT in the progress notes.	
SUD providers, when clinically appropriate, shall document member response in the progress notes.	

Restraints and Seclusion (if applicable)	Yes, No, N/A
Documentation of alternatives/other less restrictive interventions were attempted.	
Documentation of restraint/seclusion order.	
Documentation of physician notification of restraint.	
Documentation of member face to face assessment by a physician or physician extender (e.g., PA, NP, APRN) within one hour of restraint initiation/application.	
Documentation must show evidence of consultation with the physician or physician extender (e.g., PA, NP, APRN) within 24 hours of restraint initiation/application.	
Documentation of members' parent/guardian notification of restraint/seclusion as soon as possible of restraint occurring (children only).	

Patient Safety	Yes, No, N/A
If the member was placed on a special watch for harmful behavior, documentation of the appropriate precautions taken, and monitoring occurred.	
If the member was placed in restraints/seclusion, documentation of required monitoring. (A patient in seclusion or restraints shall be evaluated every 15 minutes and documentation of these evaluations shall be entered into the patient's record.)	
If the member was a victim of abuse or neglect, documentation of report to the appropriate protective agency and Health Standards, as applicable.	

Cultural Competency	Yes, No, N/A
Cultural needs of the member were assessed.	
Identified cultural needs of the member were incorporated into treatment, if applicable.	
Primary language spoken by the member is documented.	
Any translation needs of the member are documented, if applicable.	
Language needs of the member were assessed (i.e. preferred method of communication), if applicable.	
Identified language needs of the member were incorporated into treatment, if applicable.	
Religious/Spiritual needs of the member were assessed.	
Identified religious/spiritual needs of the member were incorporated into treatment, if applicable.	
Racial needs of the member were assessed. (i.e. oppression, privilege, prejudice…etc.), if applicable.	
Identified racial needs of the member were incorporated into treatment, if applicable.	
Ethnic needs of the member were assessed.	
Identified ethnic needs of the member were incorporated into treatment, if applicable.	
Sexual health related needs were assessed.	
Identified sexual health related needs of the member were incorporated into treatment, if applicable.	

Adverse Incidents	Yes, No, N/A
For members 0 to 18, documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery.	
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within 1 business day of discovery.	
Documentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate.	
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery.	

Discharge Planning	Yes, No, N/A
Documentation of discussion of discharge planning/linkage to next level of care.	
Appointment date and/or time period of follow up with transitioning behavioral health provider documented on the discharge plan. If not, barriers noted, when member is discharged or transitioned to a different level of care.	
There is documentation that communication/collaboration occurred with the receiving clinician/program. If not, barriers noted, when member is discharged or transitioned to a different level of care.	
PCP appointment date and/or time period of follow up documented if medical co morbidity present. If not, barriers noted, when member is discharged or transitioned to a different level of care.	
Medication profile provided to outpatient provider during transition of care. If not, barriers noted, when member is discharged or transitioned to a different level of care.	
Medication profile reviewed with member during transition of care, when member is discharged or transitioned to a different level of care.	
Course of treatment (the reason(s) for treatment and the extent to which treatment goals were met) reflected in the discharge summary, when member is discharged or transitioned to a different level of care.	
A discharge summary details the recipient's progress prior to a transfer or closure, when member is discharged or transitioned to a different level of care.	

A discharge summary must be completed within 14 calendar days following a recipient's discharge or transition to a different level of care.	
Additional SUD Requirements	
Documentation of discharge/transfer planning at admission.	
Documentation of referrals made as needed, if applicable.	
TGH	
Discharge planning within the first week of admission with clear action steps.	
Discharge planning with target dates outlined in the treatment plan.	

XIII. CPG - Major Depressive Disorder	
A. The provider found enough evidence to support the diagnosis of MDD by ruling out medical conditions that might cause depression and/or complicate the treatment.	
B. The provider delivered education about MDD and its treatment to the member, and if appropriate, to the family.	
C. If psychotic features were found, the treatment plan included the use of either antipsychotic medication or ECT, or clear documentation why not.	
D. If MDD was of moderate severity or above, the treatment plan used a combination of psychotherapy and antidepressant medication, or clear documentation why not.	
E. The psychiatrist delivered education about the medication, including signs of new or worsening suicidality, and the high-risk times for this side effect.	
F. If provider was not an M.D., there was documentation of a referral for a medical/psychiatric evaluation if any of the following are present: psychotic features, complicating medical/psychiatric conditions, severity level of moderate or above.	
XIV. CPG: ADHD	
A. Diagnosis was determined based on input/rating scales from family members/caregivers, teachers, and other adults in the member's life.	
B. Record indicated that the medical evaluation was reviewed to rule out medical causes for the signs and symptoms.	
C. Psychoeducation was delivered to all members with ADHD and in the case of minors, to the parents/caregivers.	
D. The treatment plan and rationale as well as available treatments, including medications and their benefits, risks, side	

effects, were discussed with the member and the parent/caregiver in the case of minors.	
E. Record indicated the use of family interventions that coach parents on contingency management methods.	
F. Record indicated a comprehensive assessment for comorbid psychiatric disorders was conducted.	
XV. CPG: Substance Use	
A. Education was delivered about substance-use disorders.	
B. A plan for maintaining sobriety, including strategies to address triggers was developed, and the role of substance use in increasing suicide risk was discussed.	
C. The treatment plan included a referral to self-help groups such as AA, Al-Anon, and NA.	
D. Evaluation included the consideration of appropriate psychopharmacotherapy.	
E. For MD providers, evidence that abstinence-aiding medications were considered.	
F. If provider was not a MD, there was evidence that a referral for abstinence-aiding medication or a diagnostic consultation was considered.	
XVI. CPG: Schizophrenia	
A. Assessment for other psychiatric disorders and medical conditions that may cause symptoms and/or complicate treatment was completed.	
B. Education was delivered regarding schizophrenia and its treatment to the member and the family.	
C. If significant risk was found, the provider implemented a plan to manage the risk, including a plan for diminishing access to weapons/lethal means.	
D. If provider was a not an MD, documentation of a referral for a psychiatric evaluation was included in the record.	
E. If a psychiatric referral was made, the provider documented the results of that evaluation and any relevant adjustments to the treatment plan.	
F. If provider was an MD, and if there was several unsuccessful medication trials and/or severe suicidality, then the member was considered for ECT and/or Clozapine.	
XVII. CPG: Generalized Anxiety Disorder	
A. Diagnosis for GAD based on DSM-5 criteria	
B. Member received education from physician about GAD, options for treatment and general prognosis	
C. CBT based psychotherapy and/or psychopharmacotherapy considered as first line treatment.	

D. Ongoing monitoring of symptoms that are accessed for severity	
XVIII. CPG: Bipolar Disorder	
A. Diagnosis is documented by type (acute manic, hypomania, mixed, or acute depressive episode)	
B. Complete psychological assessment documented First-line treatment: psychotherapy using trauma-focused therapy or stress management and/or pharmacotherapy	
C. Psychoeducation, psychotherapy and family intervention provides as indicated	
D. Evidence of monitoring medication and managing adverse effects	
XIX. CPG: Suicide Risk	
A. High to intermediate level of acute risk for suicide and Risk Assessment documented	
B. Psychosocial evaluation completed	
C. Assessment of lethal means and limited access to lethal means if needed	
D. Assessment for indications for inpatient admission	
E. Safety plan development if risk is not imminent including social support	
F. Continued monitoring of patient status and reassessment of risk in follow-up contacts	
CPG: Post-Traumatic Stress Disorder	
A. Diagnosis is documented, including the traumatic event and prevailing symptoms	
B. Complete assessment is documented, including triggers and intensity of symptoms	
C. Evidence of assessment of self-harm and/or risk of harm to others	
D. Evaluation for appropriate psychopharmacotherapy	
E. Psychotherapy and/or other therapies provided	
CPG: Oppositional Defiant Disorder	
A. Diagnosis is documented	
B. Comprehensive evaluation looking for physical or other mental health issues that may cause problems of behavior from multiple sources	
C. Identification of other treatable mental health and/or learning conditions, as applicable.	
D. Evaluation considered treatment of combination therapy, parent-management training programs, family therapy, cognitive problem-solving skills training, social-skills program and school-based programs, and medication therapy.	
E. Evidence of ongoing monitoring and improvement/ decline in condition	