Behavioral Health

Treatment Record

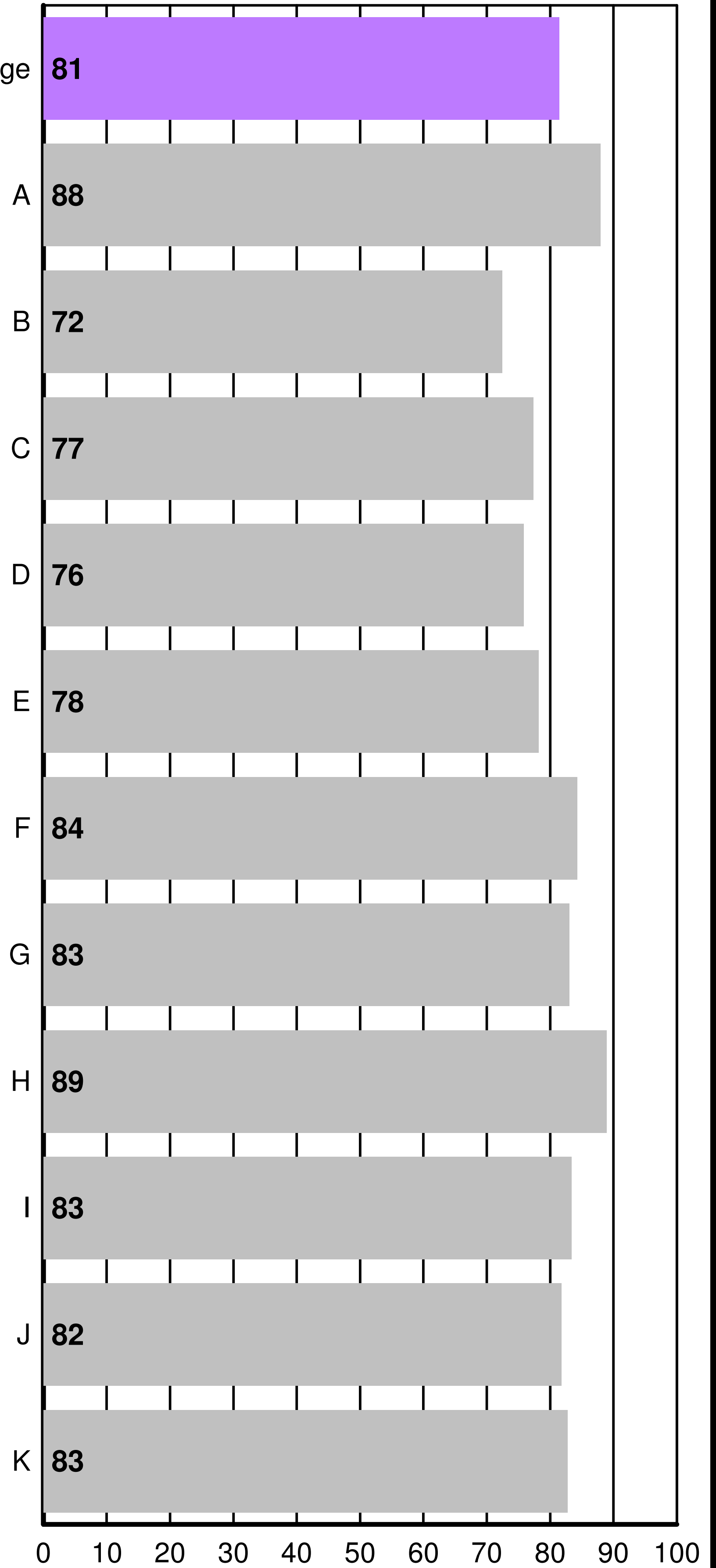
Audit Report

2009

PrimeWest HEALTH

2009 Behavorial HealthTreatment Record Audit Report

Overall Composite Table



Overall Averages For Individual Elements

PrimeWest Health Average

Strengths Above 90%

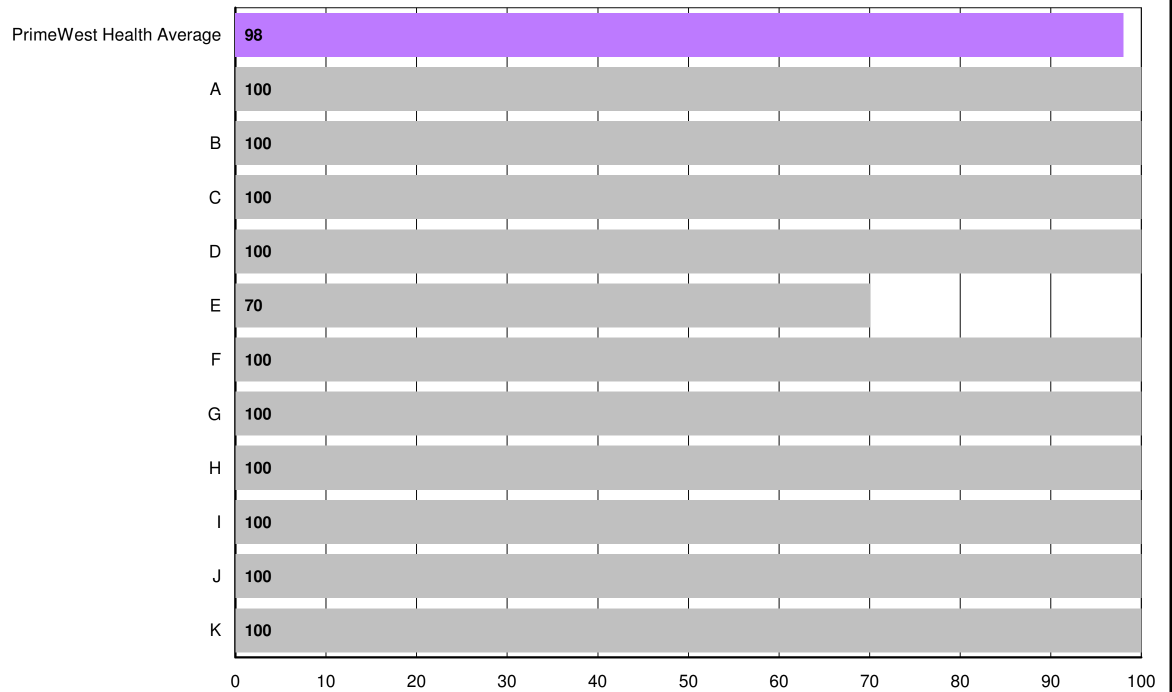
Element	Average
* A summary of preventive services is documented in a consistent place in the treatment record.	100
* At the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome are documented.	100
* Clinically significant consultation, abnormal lab and imaging reports have an explicit notation of follow-up plans.	100
* Consultation, lab and imaging reports filed in the treatment record are initialed by the practitioner who ordered them, to signify review.	100
* Discharge summaries are filed in the member's record.	100
* Laboratory and other studies are ordered, as appropriate.	100
* Note from consultant is present for each consultation requested.	100
* Presenting problem(s), along with relevant psychological and social conditions affecting the member's medical or psychiatric status, are documented.	100
* Unresolved problems from previous visits are addressed in subsequent visits.	99
* All entries are dated.	98
* Elements in the treatment record are organized in a consistent manner.	98
* All entries are legible to someone other than author.	96
* Author identification present for every entry.	96
* A medical history is easily identified and includes relevant illnesses and medical conditions.	90

Areas Identified Below 90%

Element	Average
* A social history must be documented.	89
* Evidence of coordination of care with other relevant behavioral health providers and/or medical professionals must be documented.	88
* A psychiatric history is documented including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information.	87
* A DSM-IV diagnosis is documented.	86
* Current medications prescribed by all prescribing practitioners, as well as over the counter and herbal preparations, are documented.	86
* Personal biographical data includes member address, employer or school, home and work phone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information.	85
* Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.	84
* Member authorization to release private information and member information obtained from outside sources must be documented.	83
* Absence or presence of medication allergies and adverse reactions are prominently noted in treatment record.	79
* Treatment plans are consistent with diagnoses.	77
* Encounter forms or notes include information about follow-up care, visits, calls, or as applicable, discharge plans. Specific time of return is noted in weeks, months or as needed.	75
* Special status situations, when present, are prominently noted.	74
* Results of a mental status exam are documented.	70
* Informed consent for medication and treatment plan are documented.	70
* Member name present on every page.	69
* Past medical history for members under the age of 18 includes information about relevant prenatal and perinatal events, along with a complete developmental history.	54
* For members 11 years and older, there is appropriate notation concerning the past and present use of tobacco and alcohol, as well as illicit, prescribed and over-the-counter drugs.	44
* Progress notes reflect current treatment interventions.	31
* Health Care Directives are documented in the treatment record for members 18 years and older.	31

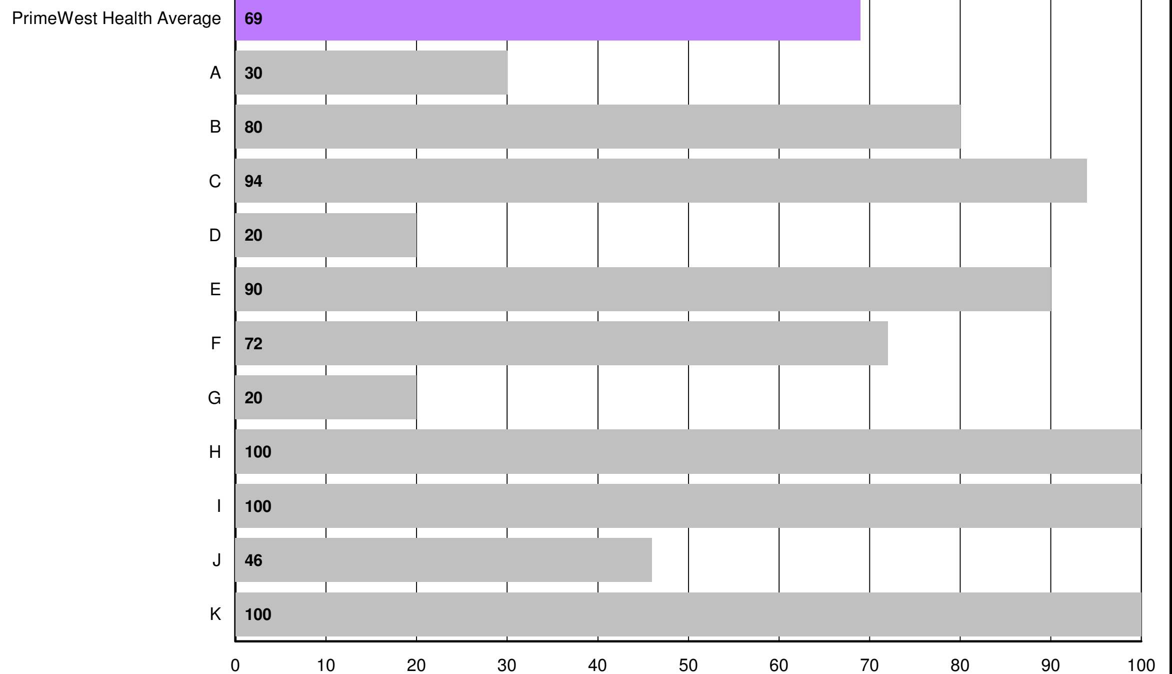
RECORD FORMAT

1. Elements in the treatment record are organized in a consistent manner.



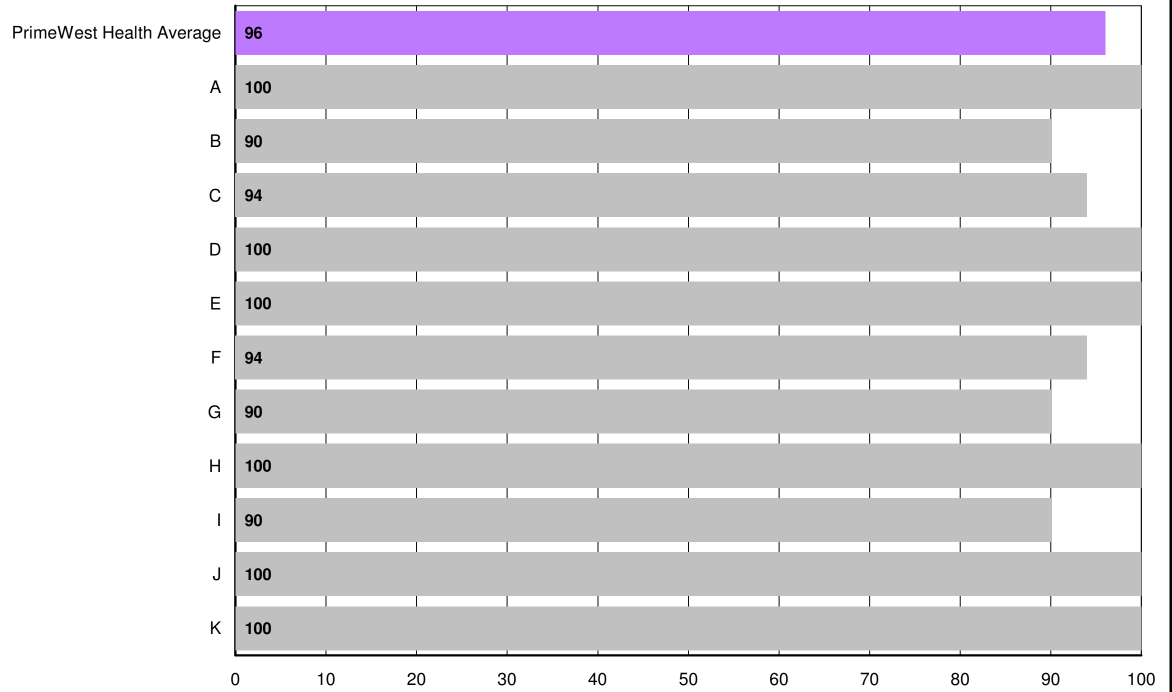
Contents are secured in place and organized in a logical, consistent manner and in chronological order. Electronic health records (EHRs) are organized in appropriately named folders so documents can be easily located; documents are stored in the correct folders.

2. Member name present on every page.



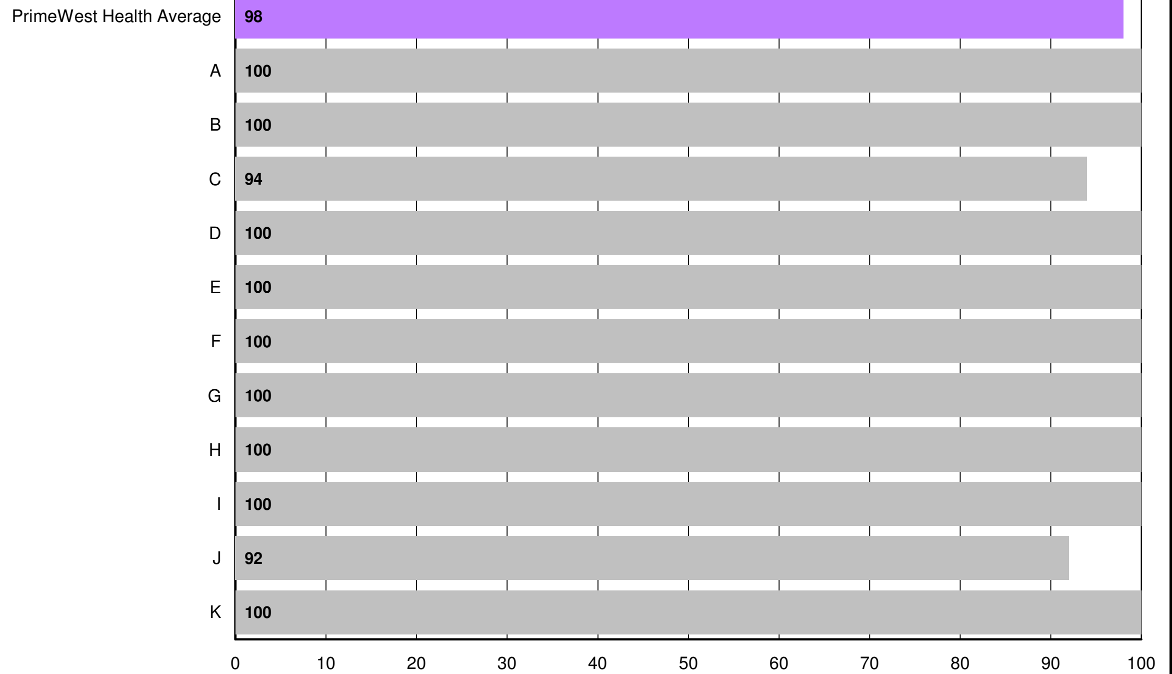
Member name is present on every page and there are no pages/entries in record that belong to another person (separate record maintained for each unique member).

3. Author identification present for every entry.



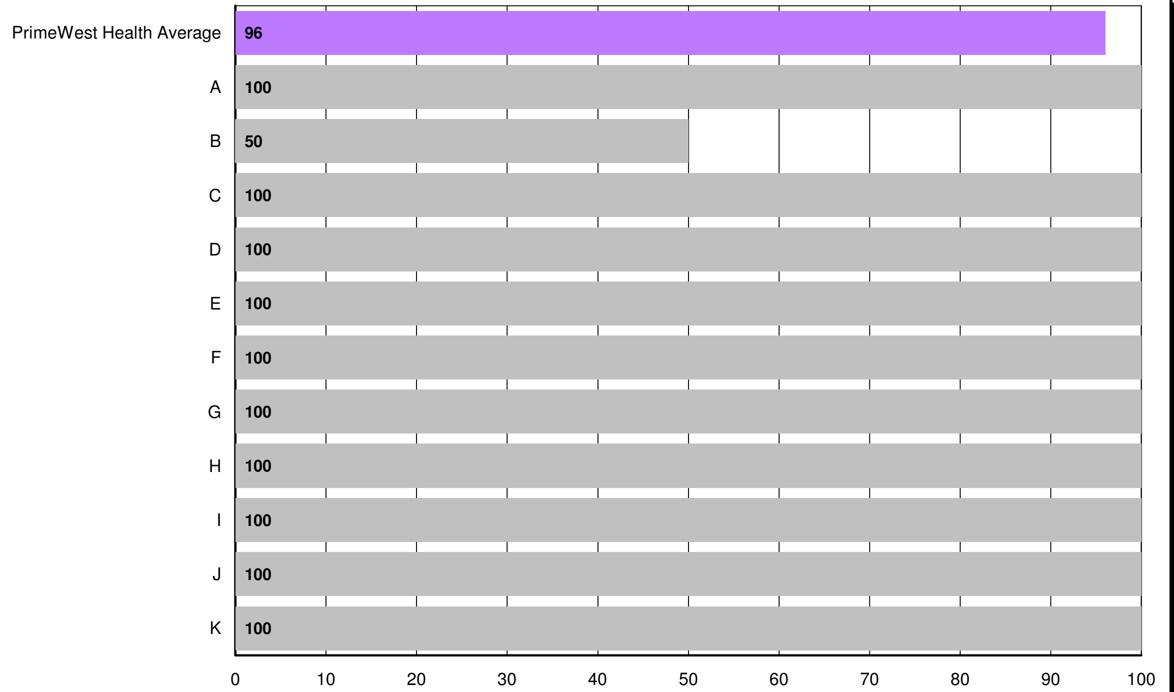
All entries contain the author's name, which may be a handwritten signature, unique electronic identifier or initials, and title/professional degree. Stamped signatures are not acceptable. Transcribed visit notes and nurse/paraprofessional entries must also meet criteria. If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note.

4. All entries are dated.



Each entry contains the date on which the entry was made, including the year. Telephone calls and triage notes are also dated.

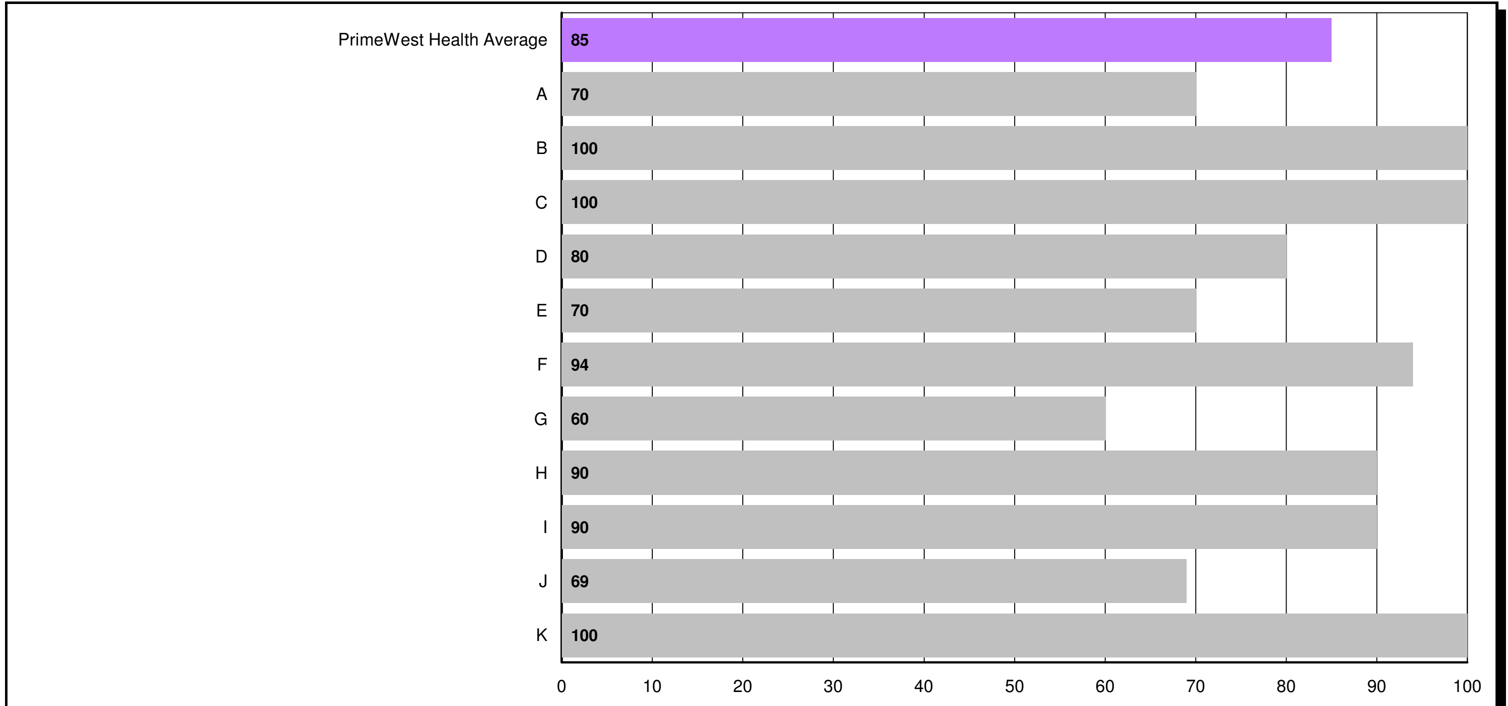
5. All entries are legible to someone other than author.



All entries are legible and presented in a standard format that allows a reader to review without the use of a standard legend/key. Unapproved abbreviations are not used. Entries left incomplete by transcriptionist are corrected by provider. Scanned documents in EHRs are legible.

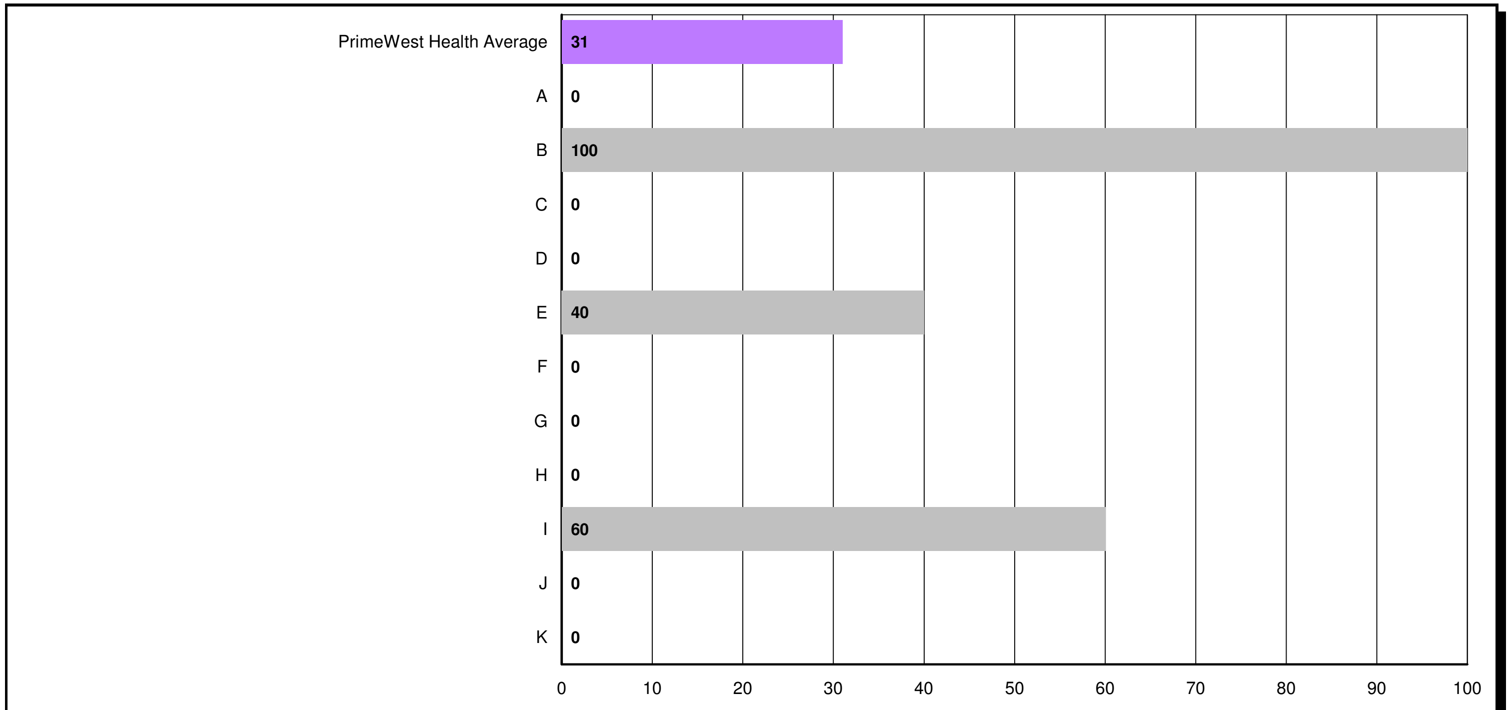
RECORD CONTENT

1. Personal biographical data includes member address, employer or school, home and work phone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information.



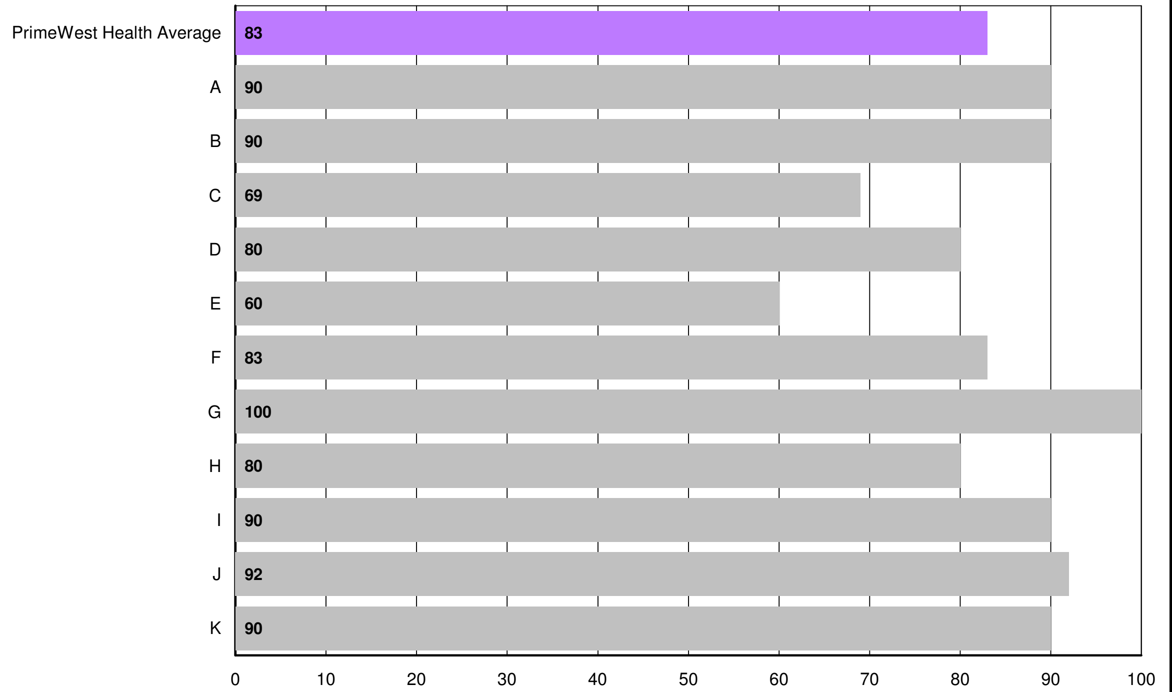
Personal biographical data is documented in a prominent location in each record and includes member's address, employer or school, home and work phone numbers including emergency contacts, marital or legal status, appropriate consent forms, and guardianship information, if applicable. Marital status, employer/school, and emergency contact information were the most commonly omitted data elements.

2. Health Care Directives are documented in the treatment record for members 18 years and older.



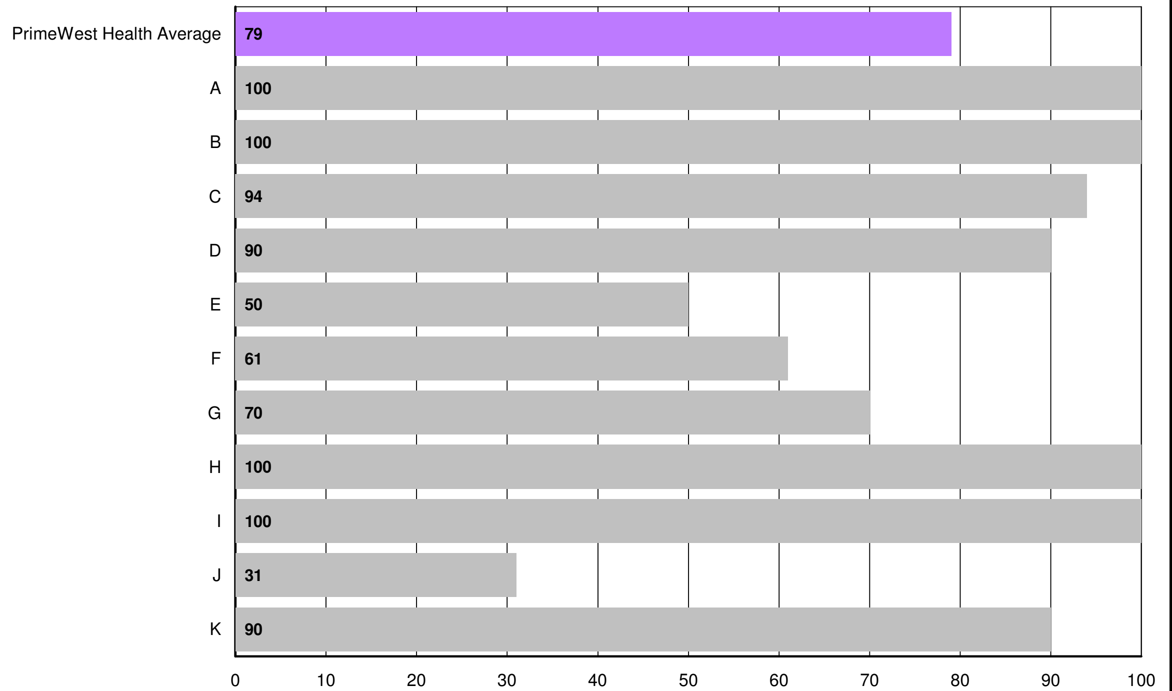
Documentation stating whether or not a member has executed a Health Care Directive (for those ages 18 and over) is in a prominent part of the record. If member has not executed a Health Care Directive, documentation showing that information was offered is included (this part of standard was not audited this year).

3. Member authorization to release private information and member information obtained from outside sources must be documented.



There is a signed authorization for all external people with whom treatment information is exchanged. This authorization to release information is current for the period covered and does not exceed one year.

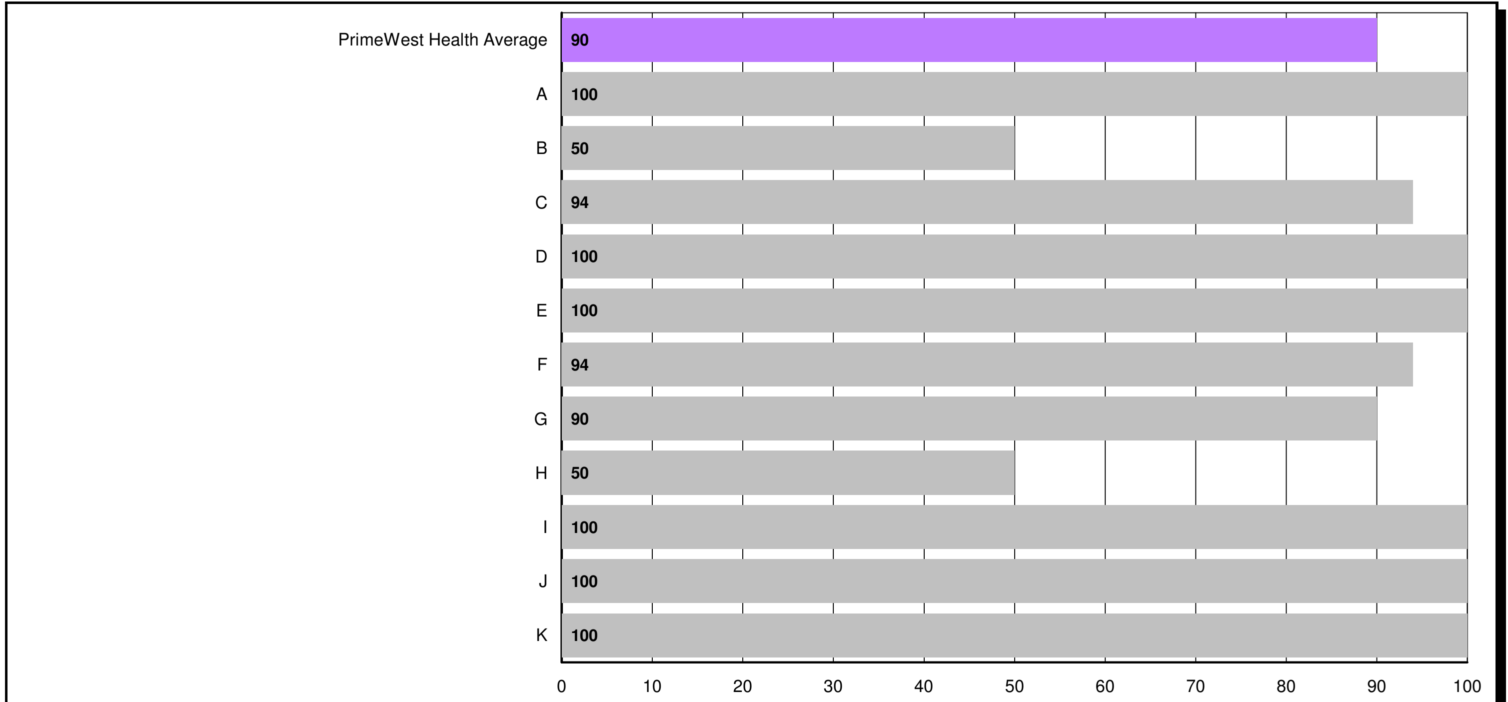
4. Absence or presence of medication allergies and adverse reactions are prominently noted in treatment record.



Absence or presence of allergies is consistently and clearly documented in a prominent location in all treatment records per clinic procedure. Allergy stamps or forms used for documentation are filled out. Allergy documentation is current.

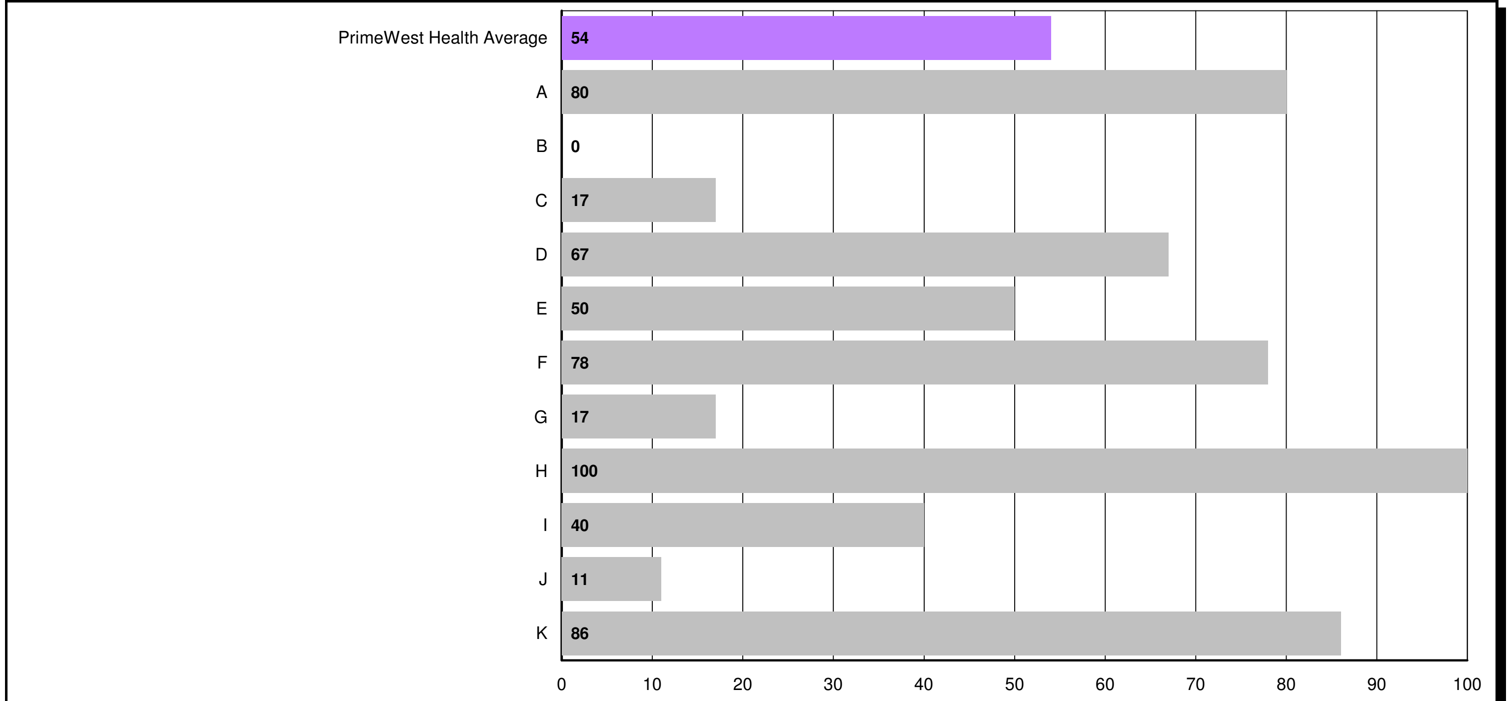
ASSESSMENT AND TREATMENT PLAN

1. A medical history is easily identified and includes relevant illnesses and medical conditions.



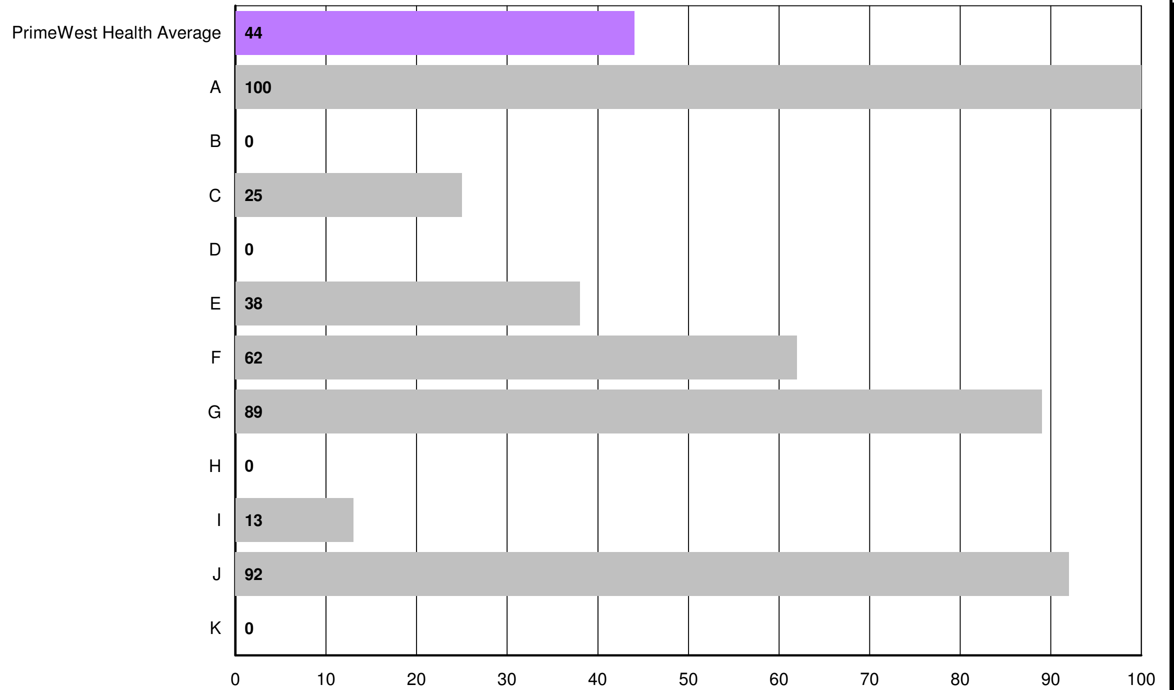
A medical history is documented in the diagnostic assessment and includes current and/or past major or chronic medical conditions, serious accidents, operations, and illnesses. Standard clinic forms for past medical history are filled out, updated, and complete.

2. Past medical history for members under the age of 18 includes information about relevant prenatal and perinatal events, along with a complete developmental history.



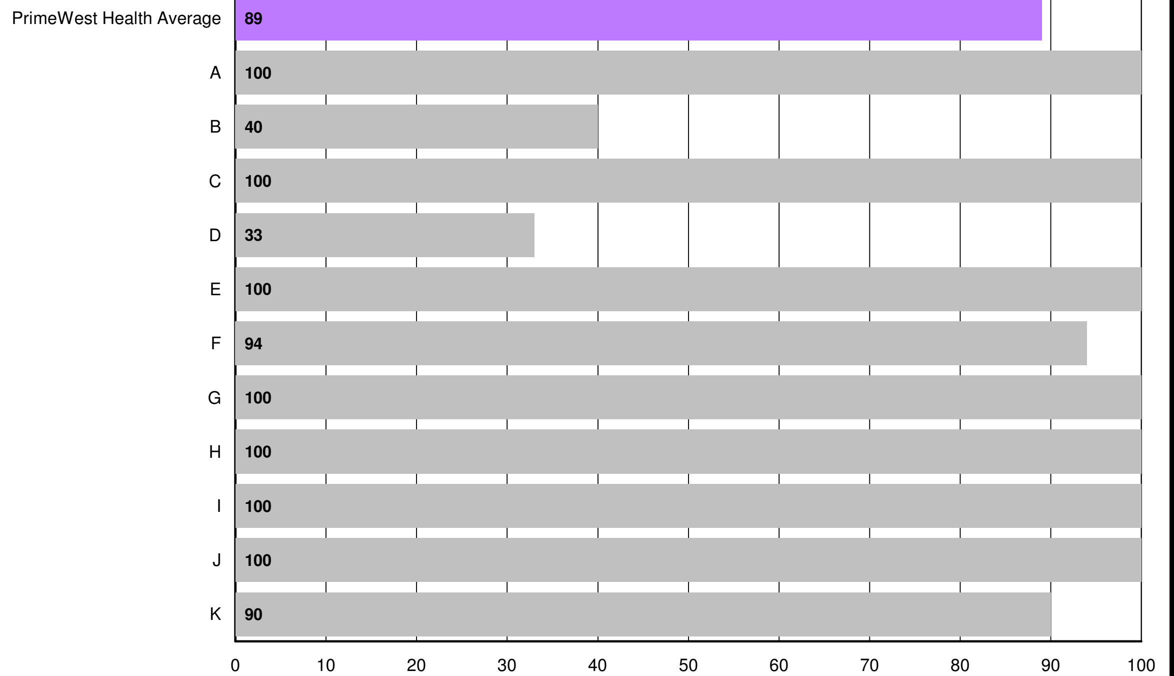
For members under the age of 18, a comprehensive developmental history is documented in the diagnostic assessment that includes relevant prenatal and perinatal events and achievement of developmental milestones. Standard clinic forms for developmental history are filled out, updated, and complete.

3. For members 11 years and older, there is appropriate notation concerning the past and present use of tobacco and alcohol, as well as illicit, prescribed and over-the-counter drugs.



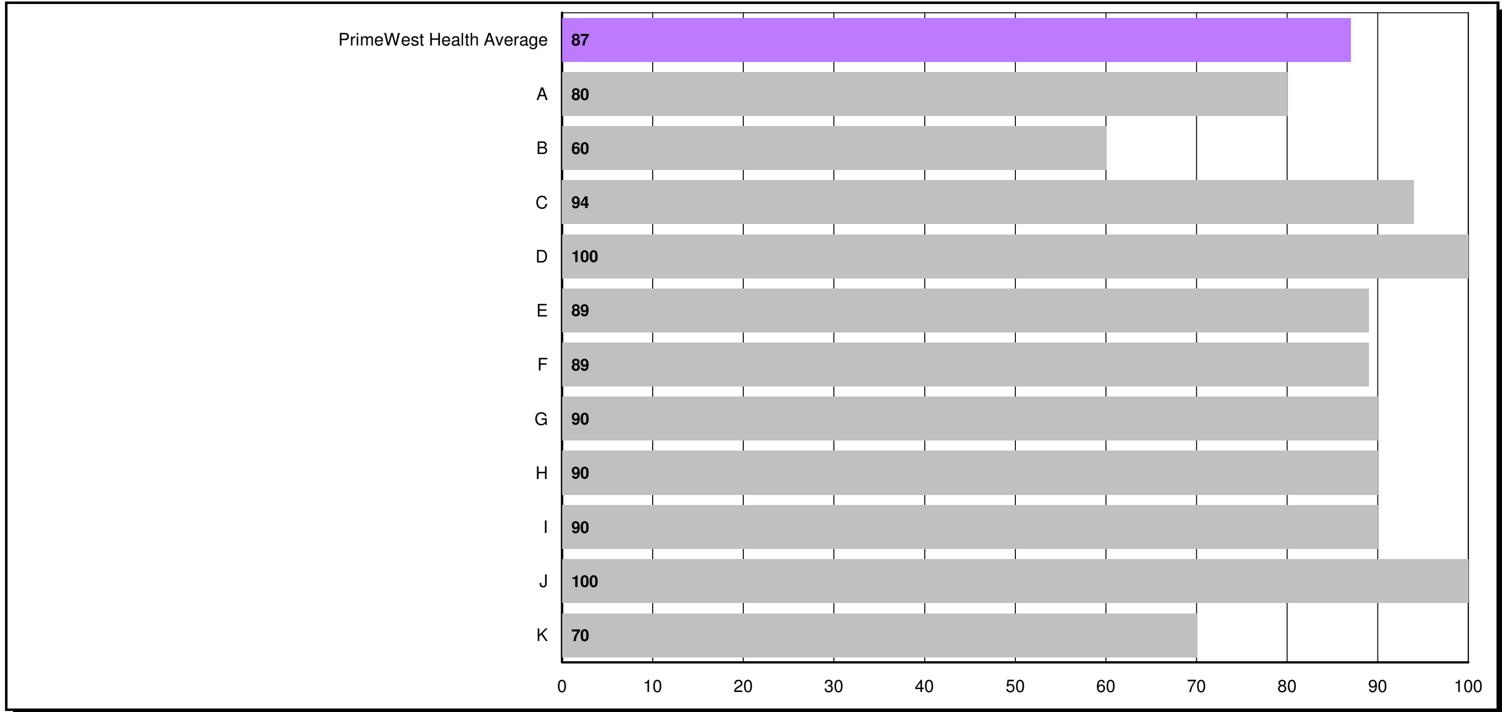
A substance use history is documented in the diagnostic assessment for those ages 11 and over. The history includes past and present use of tobacco, alcohol, illicit drugs, any misuse of prescriptions or over-the-counter drugs, and present caffeine use. Use of tobacco and caffeine were most commonly omitted. Future audits will require substance use history for those 10 years and over.

4. A social history must be documented.



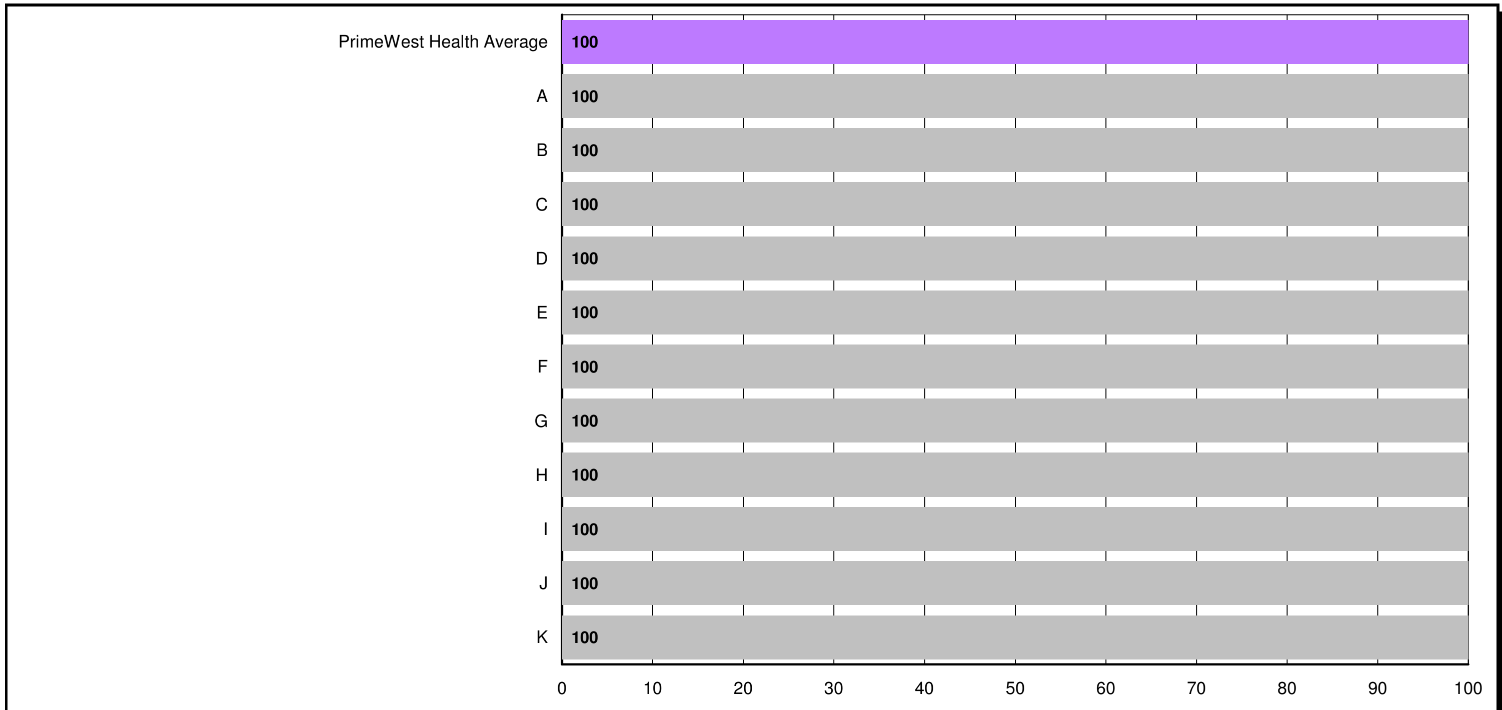
Documentation of social history in the diagnostic assessment includes: family history; current family status; history of physical, sexual, or mental abuse or trauma; current social network; and academic or vocational status.

5. A psychiatric history is documented including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information.



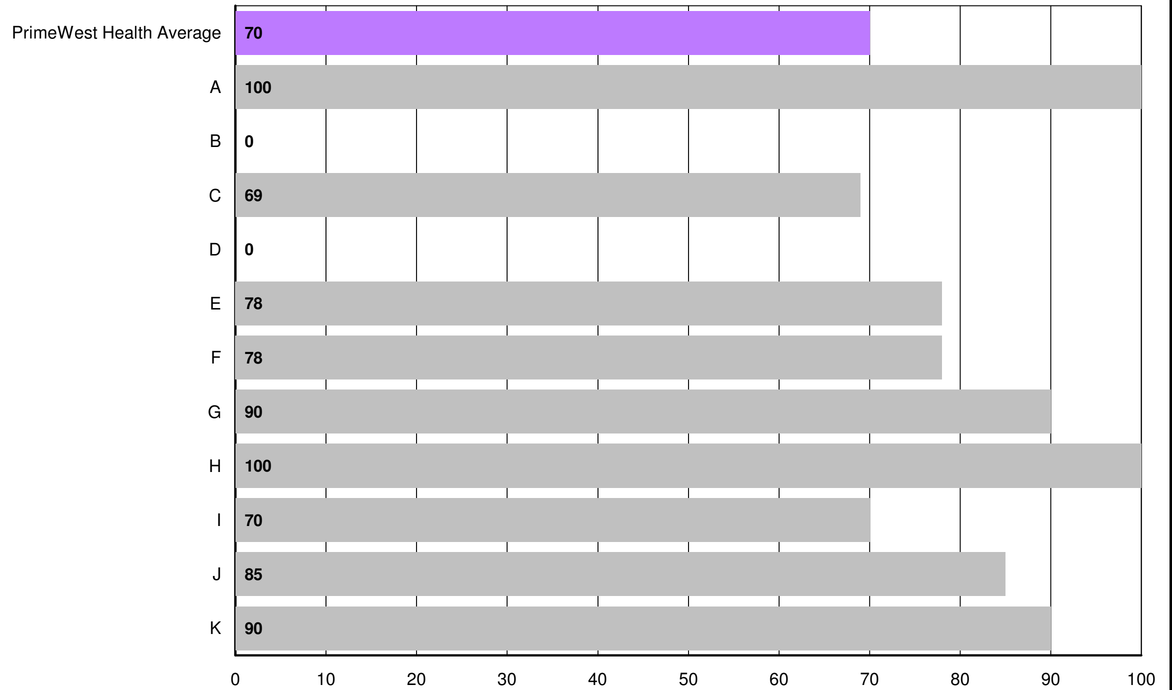
A psychiatric history is documented in the diagnostic assessment and includes, if applicable, previous treatment dates, identification of former treating practitioner(s), therapeutic interventions and responses, relevant family information, lab test results, and consultation reports.

6. Presenting problem(s), along with relevant psychological and social conditions affecting the member's medical or psychiatric status, are documented.



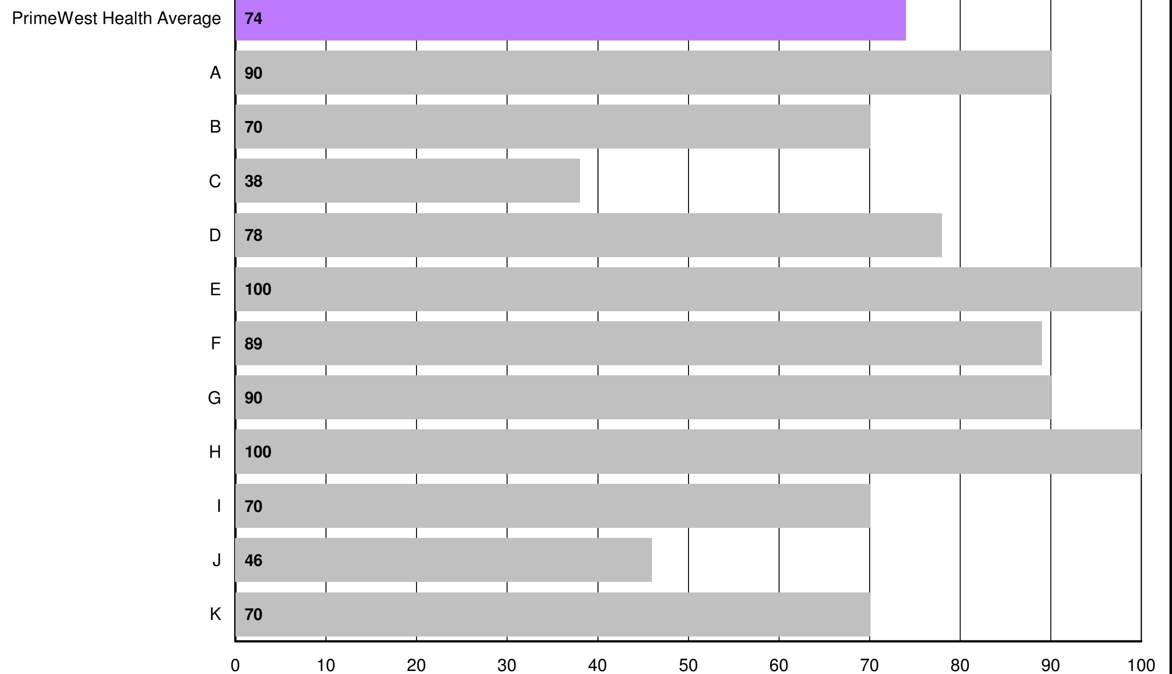
Presenting symptoms are clearly identified and documented in the diagnostic assessment, including the onset, duration, and intensity of symptoms.

7. Results of a mental status exam are documented.



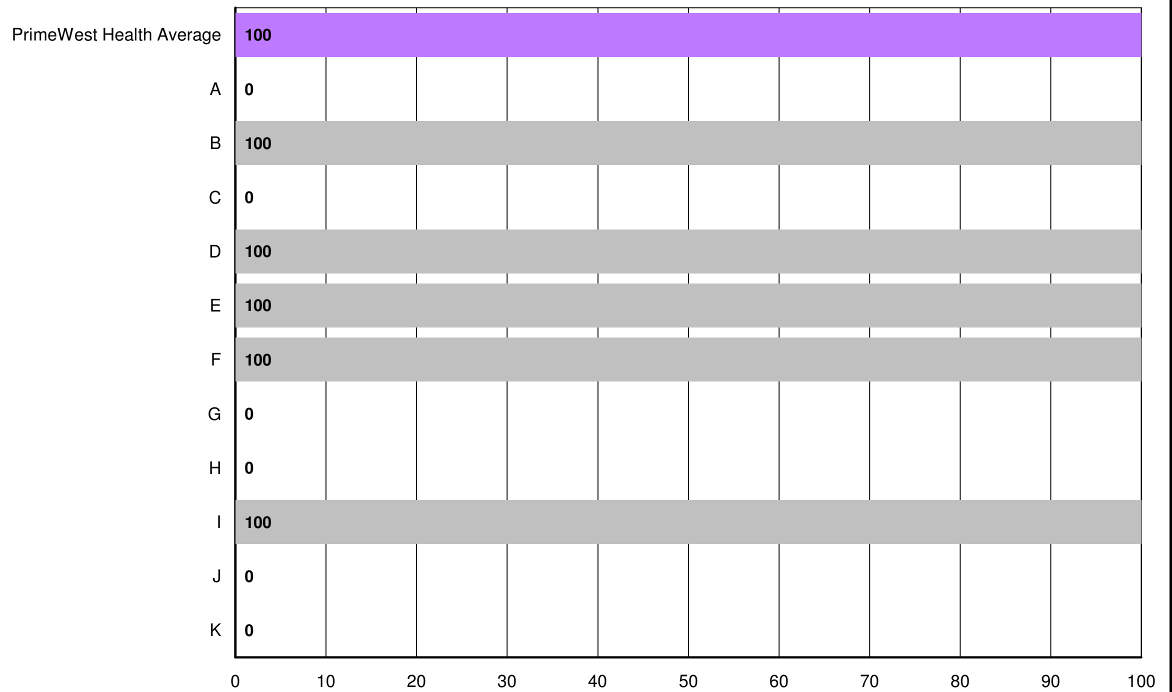
A mental status examination is documented in the diagnostic assessment that describes, at a minimum, the member's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude towards his/her symptoms per MN Rules part 9505.0323. Comments on affect, thought content (to include harm to self or others), thought process, judgment, insight, orientation status X3, attention, concentration, memory, intelligence level, and impulse control should also be included when appropriate.

8. Special status situations, when present, are prominently noted.



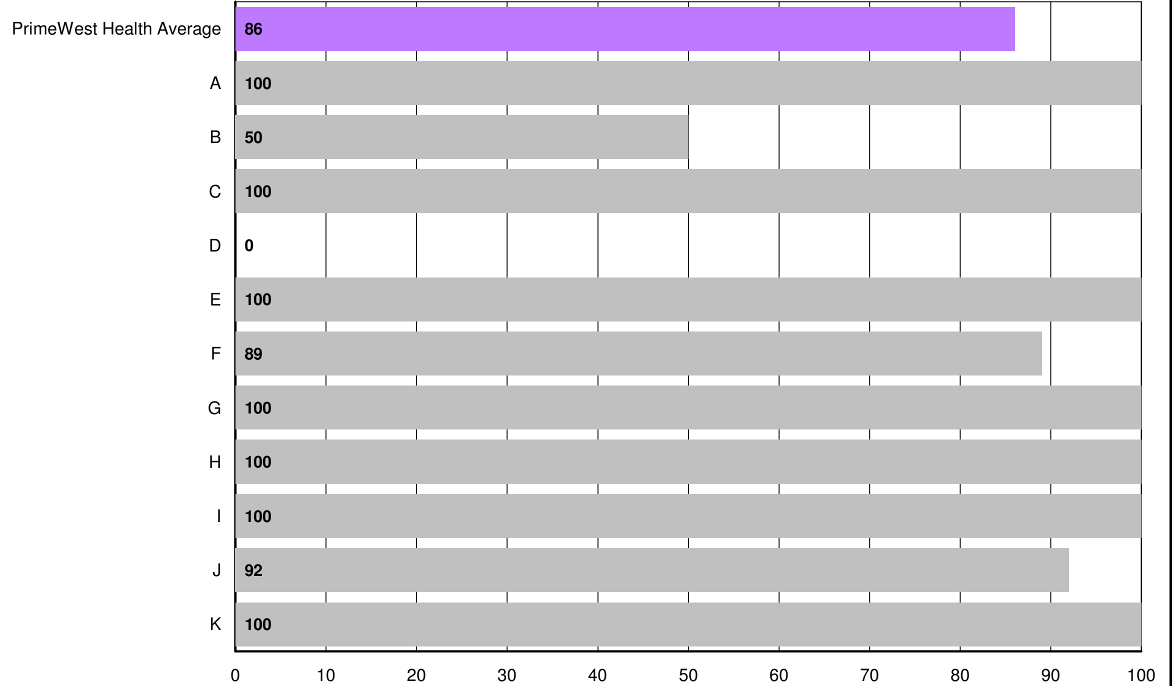
Special status situations, such as imminent risk of harm to self or others (which includes suicidal and homicidal ideation), are prominently noted in the diagnostic assessment . Continued assessment is documented in subsequent progress notes or follow-up visits.

9. Laboratory and other studies are ordered, as appropriate.



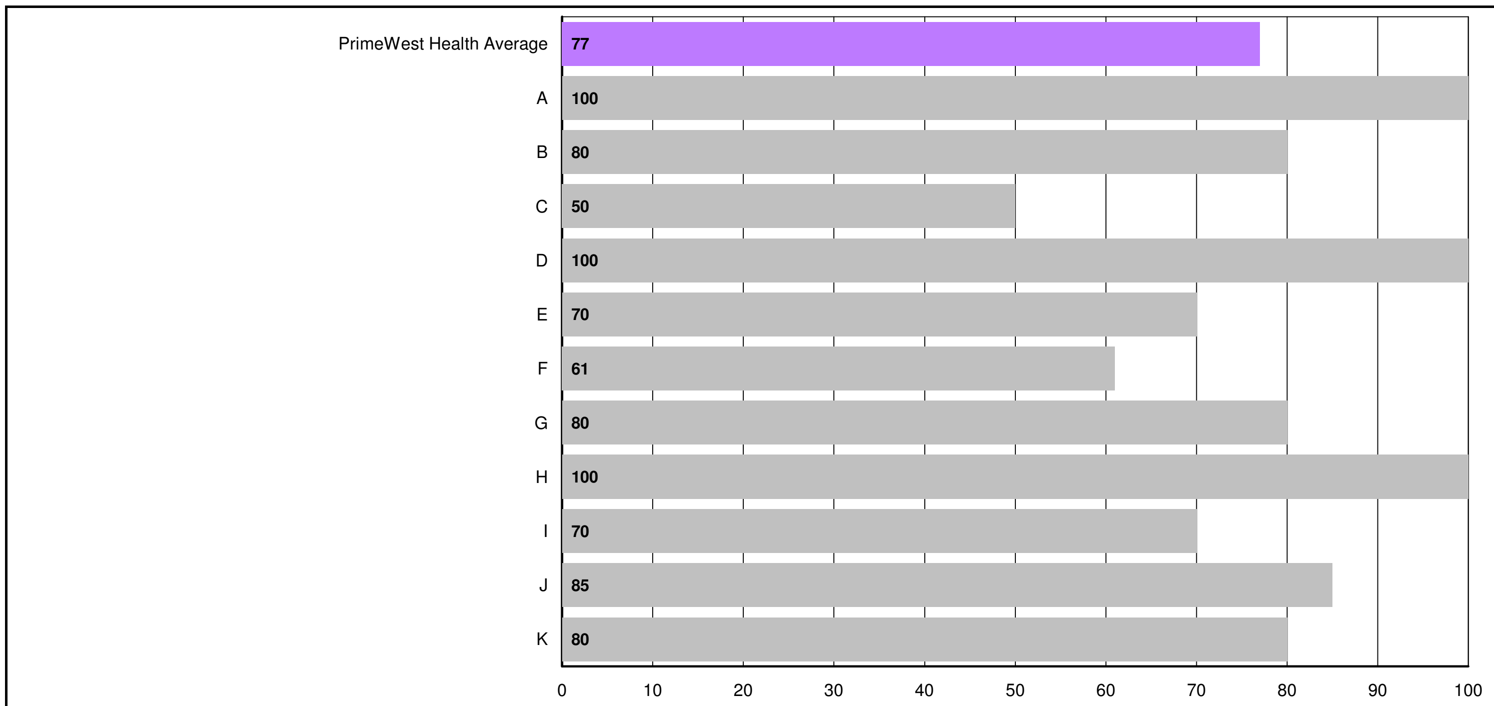
The results of all diagnostic tests and examinations, consistent with the exam and assessment, are documented in the treatment record. Documentation of the order for laboratory and/or X-ray service is also in the record.

10. A DSM-IV diagnosis is documented.



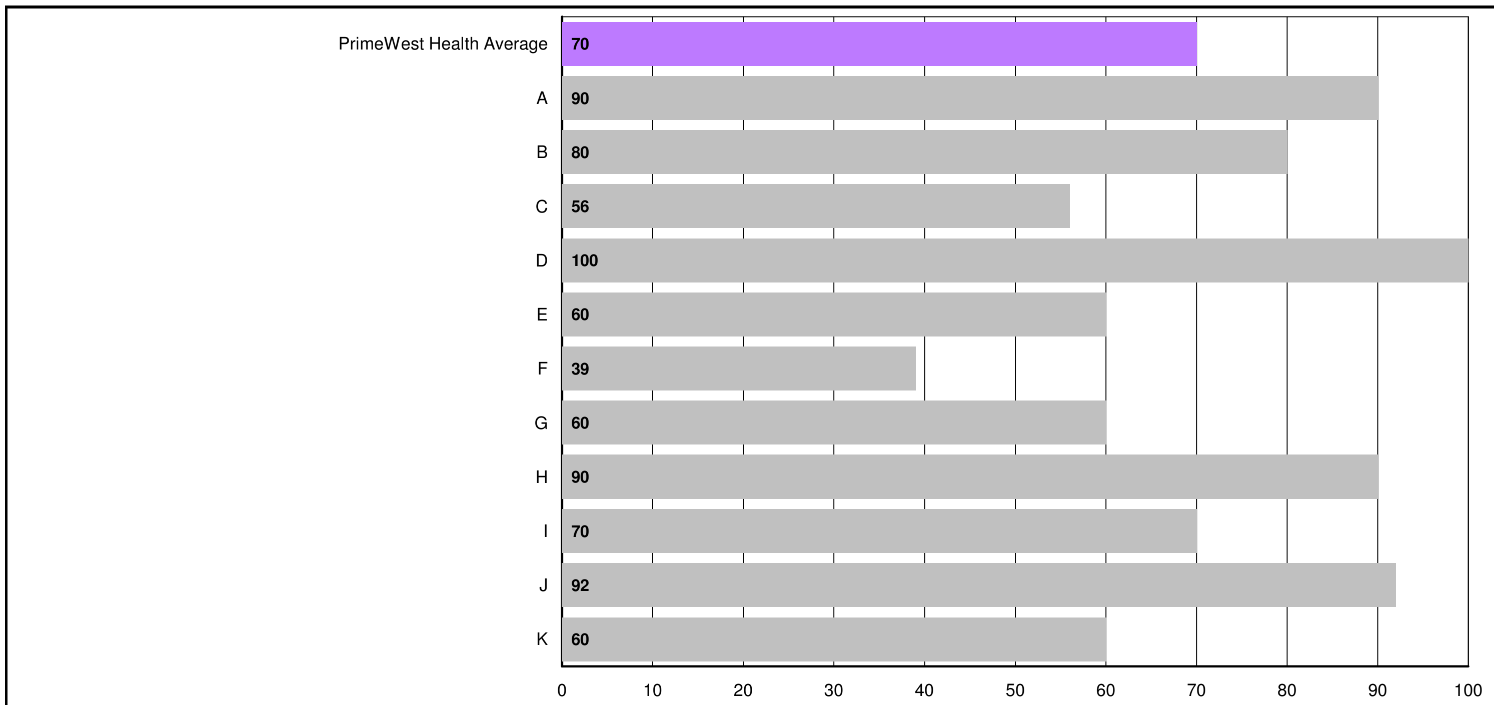
A DSM-IV diagnosis is documented in the diagnostic assessment, consistent with the presenting problems, history, mental status examination, and/or other assessment data. All five axes are documented according to the DSM-IV-TR multi-axial diagnostic system. The fifth digit of Axes I and II diagnoses are listed when applicable.

11. Treatment plans are consistent with diagnoses.



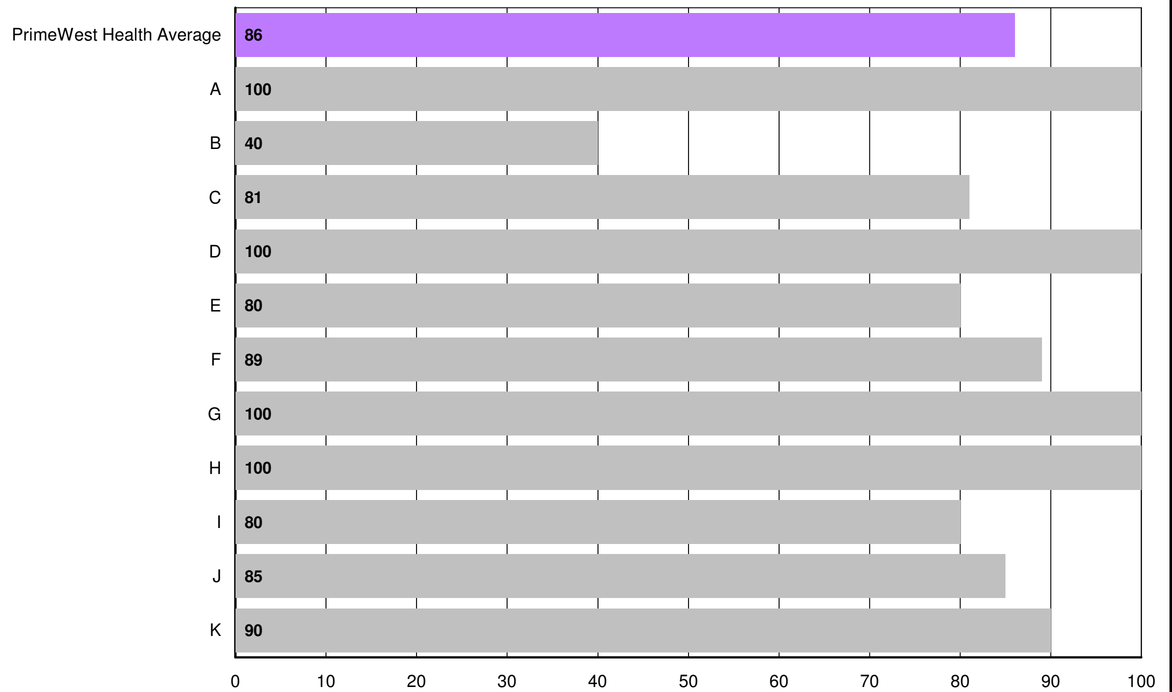
Treatment plans are consistent with diagnoses and have both objective, measurable goals and estimated time frames for goal attainment or problem resolution. This year's scores reflect the identification of at least one written measurable goal and completion of treatment plan within two psychotherapy visits. Future audits will require improvement in objective, measurable goals, with treatment plans developed no later than the end of the first psychotherapy session after completion of the diagnostic assessment per MN Rules part 9505.0323. These criteria were rarely completed and this is an area noted for improvement across all clinics.

12. Informed consent for medication and treatment plan are documented.



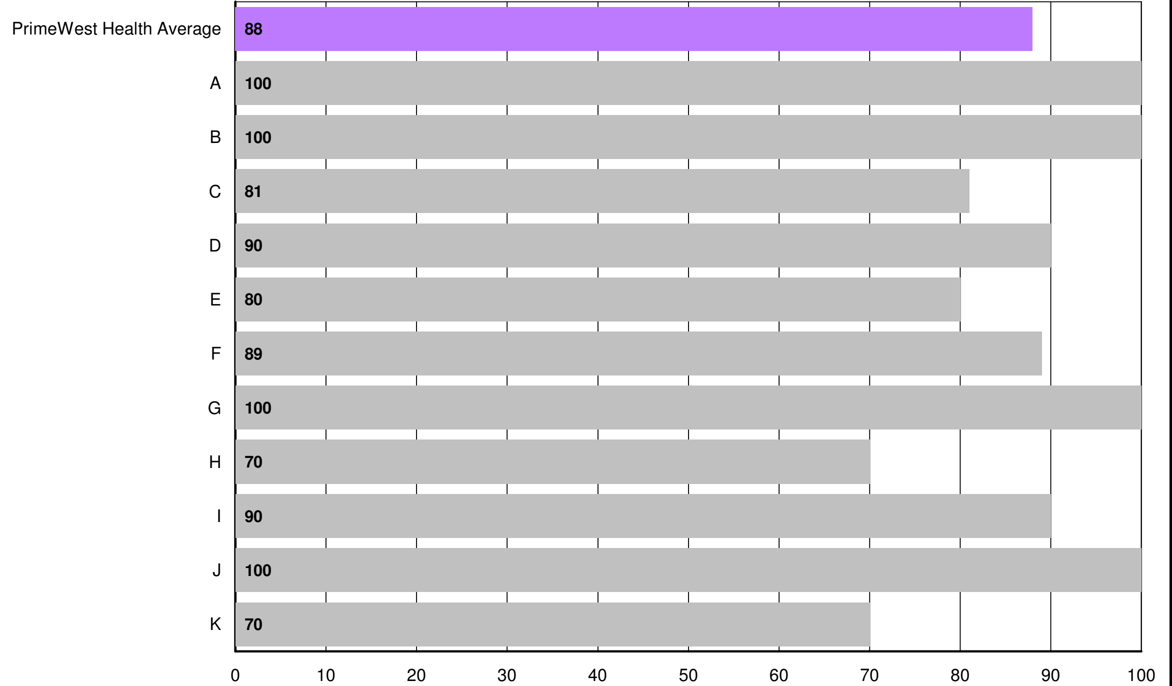
The member participated in the development of the treatment plan, signed the initial plan, and signed or initialed all updates or revisions. For a minor or adult unable to give consent, the parent or guardian signed. The plan is reviewed and signed at least once every 90 days and, if necessary, revised per MN Rules part 9505.0323. The 90-day review was rarely completed and this is an area noted for improvement across all clinics.

13. Current medications prescribed by all prescribing practitioners, as well as over the counter and herbal preparations, are documented.



Ongoing documentation and medication reconciliation of medications prescribed by all practitioners, including quantity, dosage, name of prescribed medication, and dates of initial or refill prescriptions, are clearly visible in the treatment record. Over-the-counter and herbal preparations are also clearly noted.

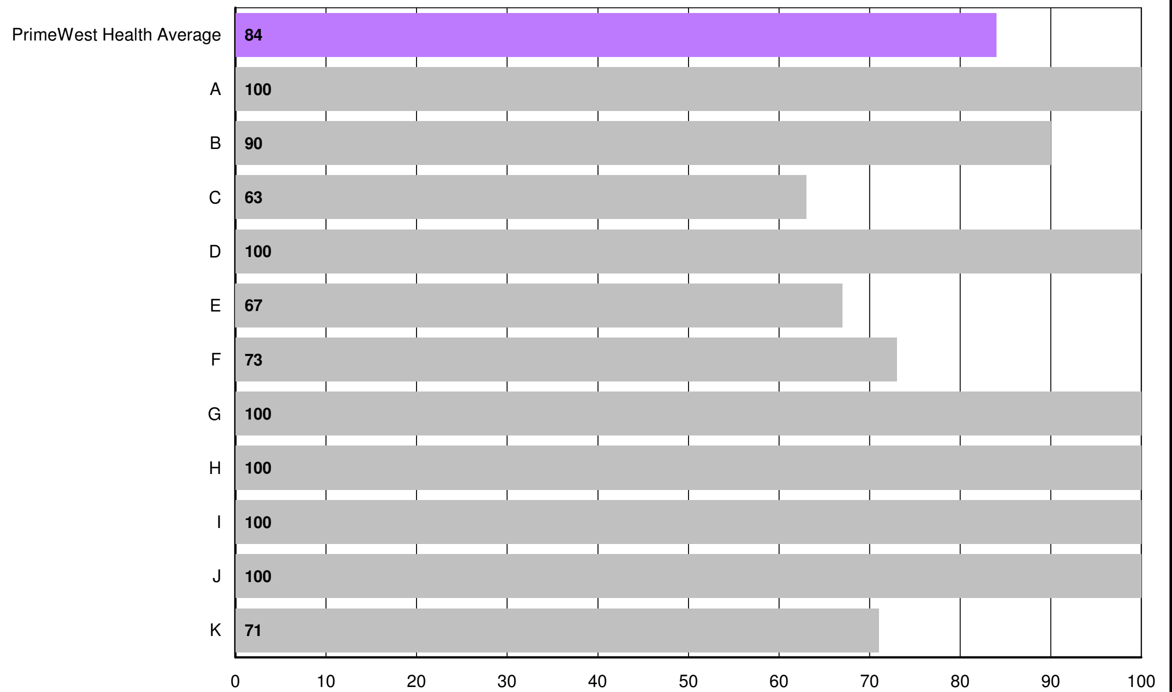
14. Evidence of coordination of care with other relevant behavioral health providers and/or medical professionals must be documented.



As required for continuity and coordination of care, all behavioral health providers conveyed pertinent information to member's primary care provider, consulting practitioner, ancillary provider, or health care institution, when appropriate. This standard excludes psychotherapy notes.

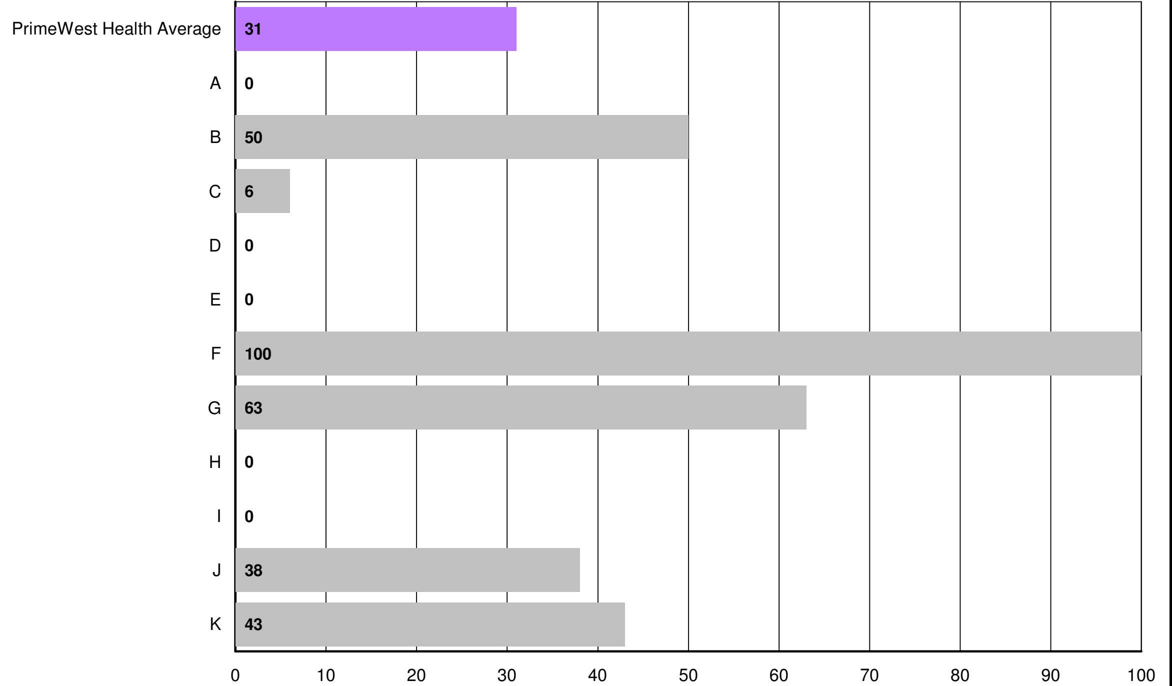
PROGRESS NOTES AND FOLLOW-UP

1. Progress notes describe member strengths and limitations in achieving treatment plan goals and objectives.



Relevant updates to the member's strengths, weaknesses, and barriers that enable or inhibit his/her ability to achieve treatment goals and objectives are noted and reflect treatment interventions that are consistent with those goals and objectives. Any education interventions are also noted. If there was no treatment plan developed, this element was also scored as a "no."

2. Progress notes reflect current treatment interventions.

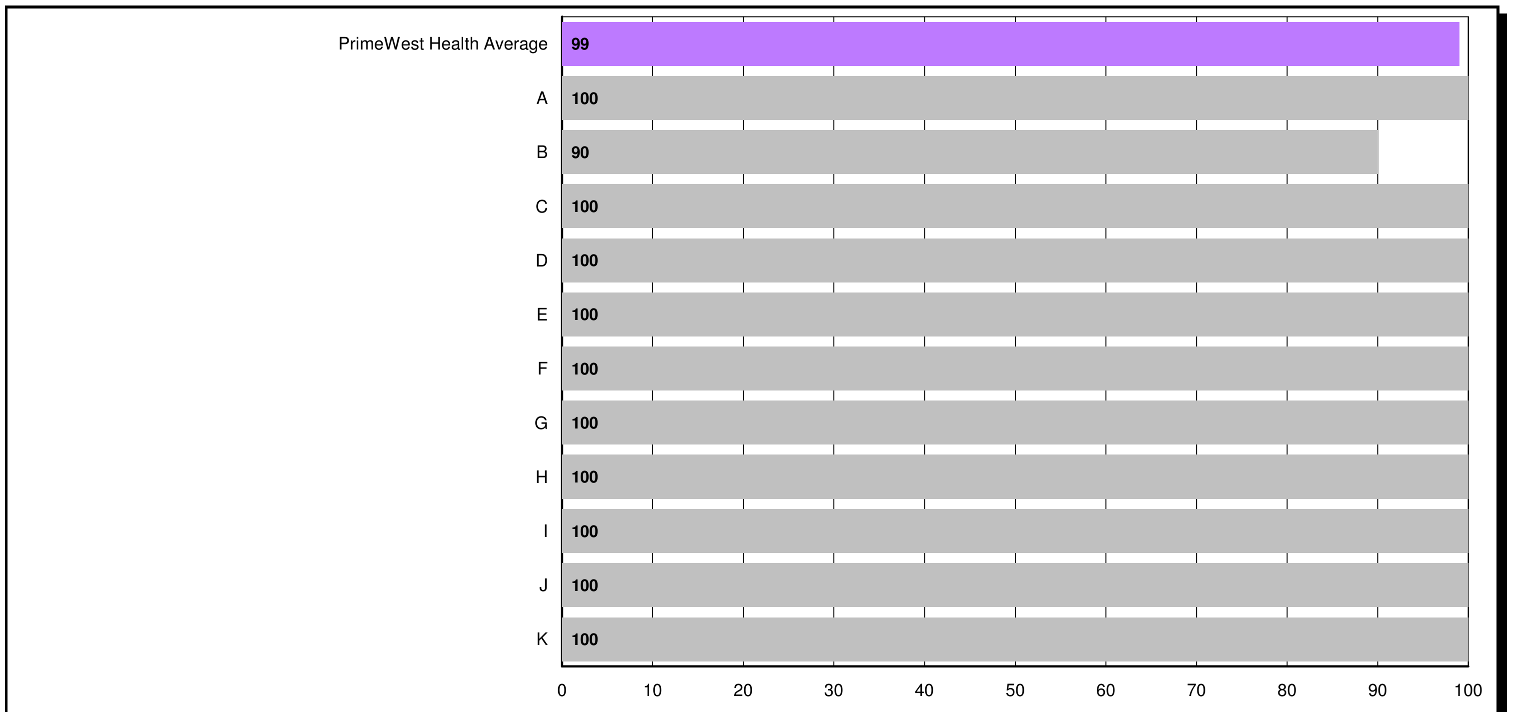


Progress notes are consistent with current treatment plans and objectives. Documentation includes continuity and coordination of care activities, as appropriate. Assessment of current mental status and special status situations includes, at a minimum, thought content. More specifically, imminent risk of harm to self or others (which includes suicidal and homicidal ideation) is documented.

3. Encounter forms or notes include information about follow-up care, visits, calls, or as applicable, discharge plans. Specific time of return is noted in weeks, months or as needed.

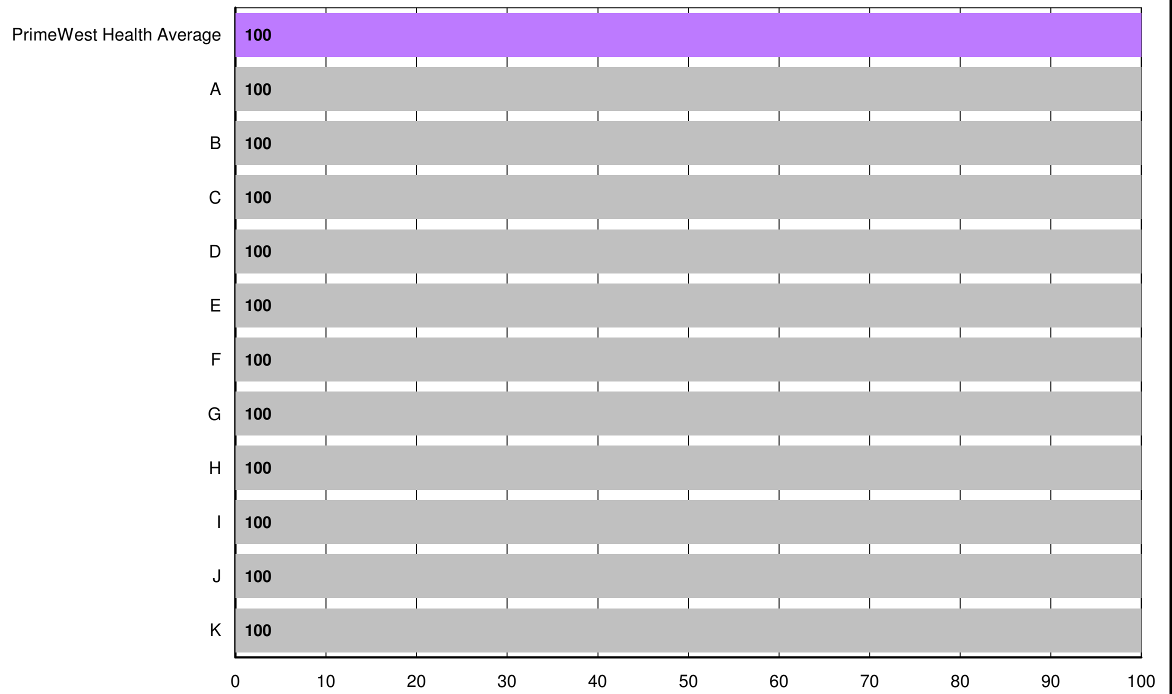
There is notation in each entry about need for follow-up care, plans for a return visit, or termination of treatment. Telephone encounters with people who are relevant to treatment are documented in the treatment record and reflect practitioner review. The specific date or time frame of a return visit is noted.

4. Unresolved problems from previous visits are addressed in subsequent visits.



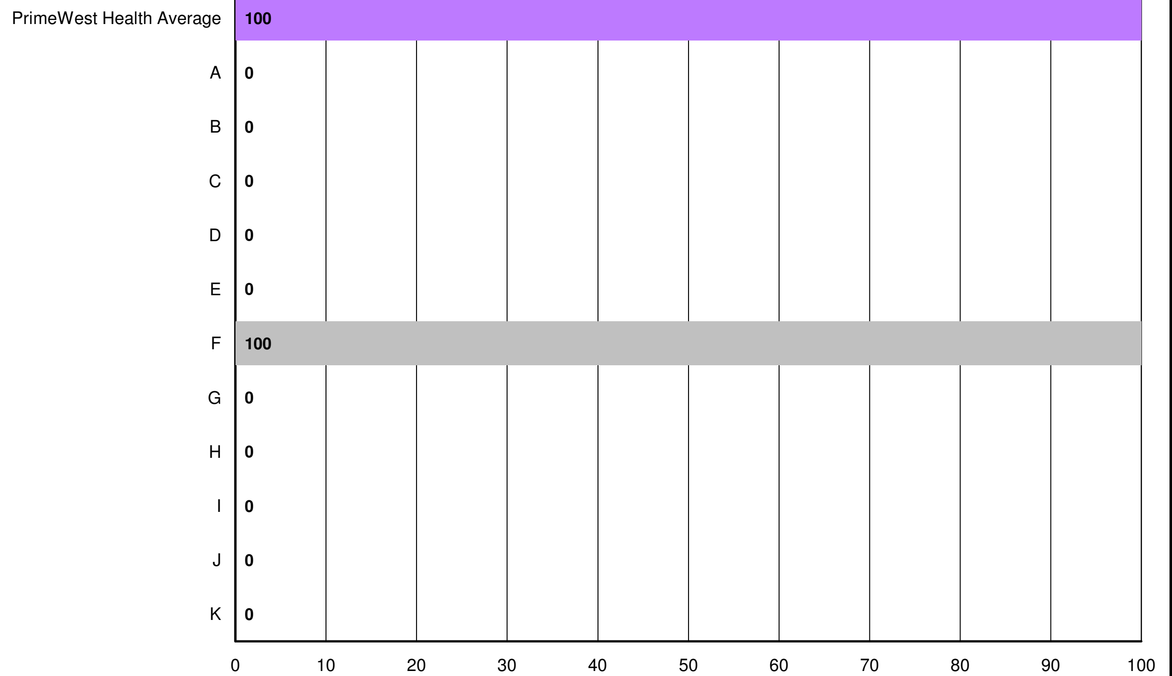
Continuity of care from one visit to the next is demonstrated when follow-up of unresolved problems from previous visits is documented in subsequent visit notes. The record reports the member’s progress or response to treatment and changes in the treatment or diagnosis.

5. A summary of preventive services is documented in a consistent place in the treatment record.



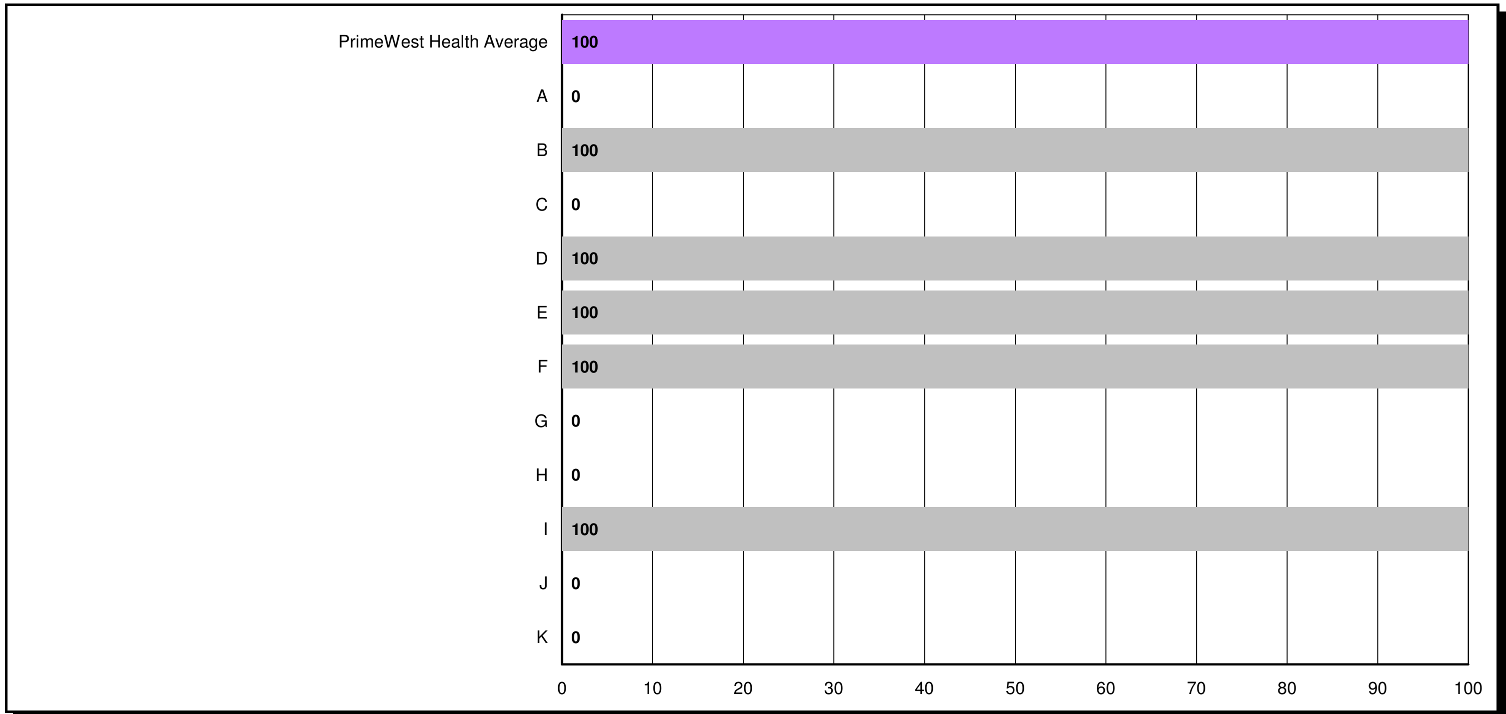
Recommendations or referrals for preventive or other external services (e.g., stress management, relapse prevention, wellness programs, lifestyle changes, or community services) are documented.

6. Note from consultant is present for each consultation requested.



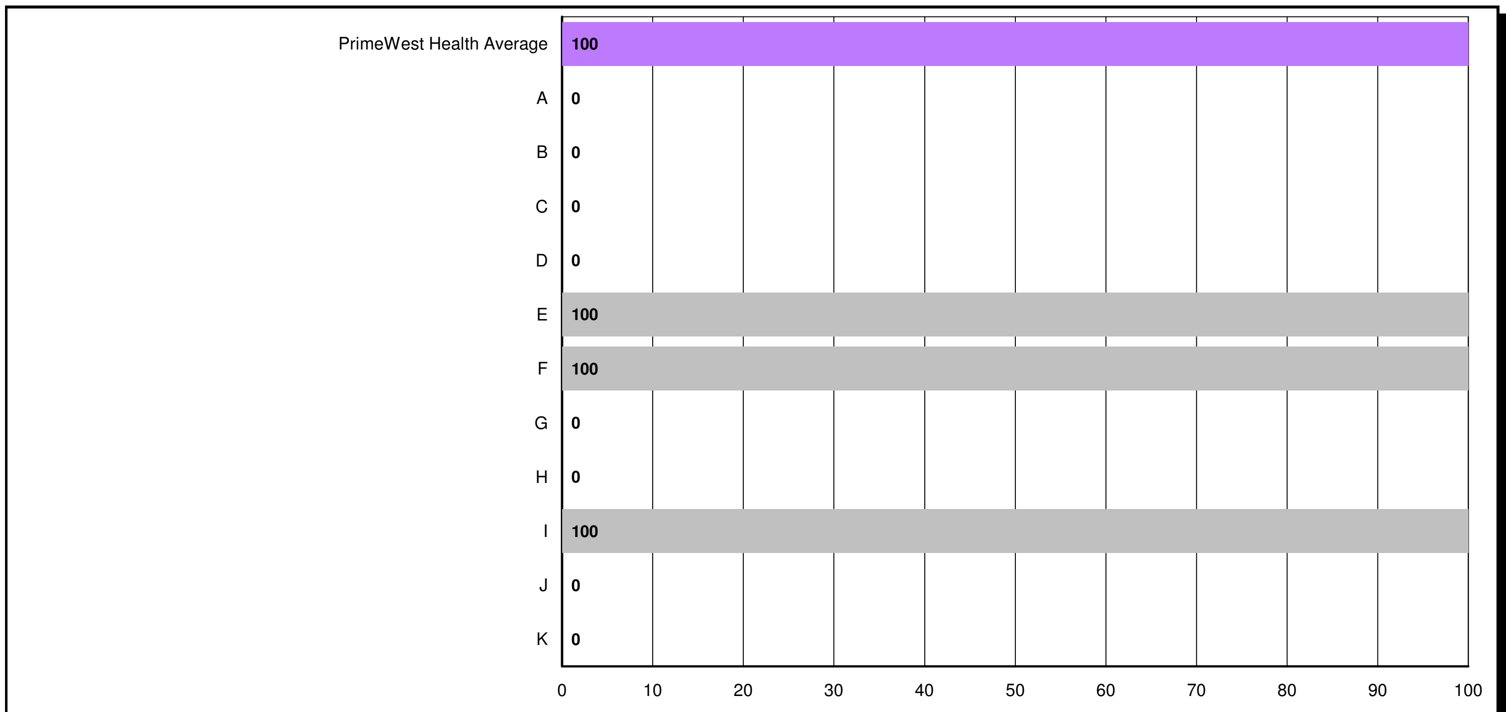
Treatment records include consultation reports/summaries that correspond to specialist referrals or documentation that practitioner attempted to obtain reports that were not received.

7. Consultation, lab and imaging reports filed in the treatment record are initialed by the practitioner who ordered them, to signify review.



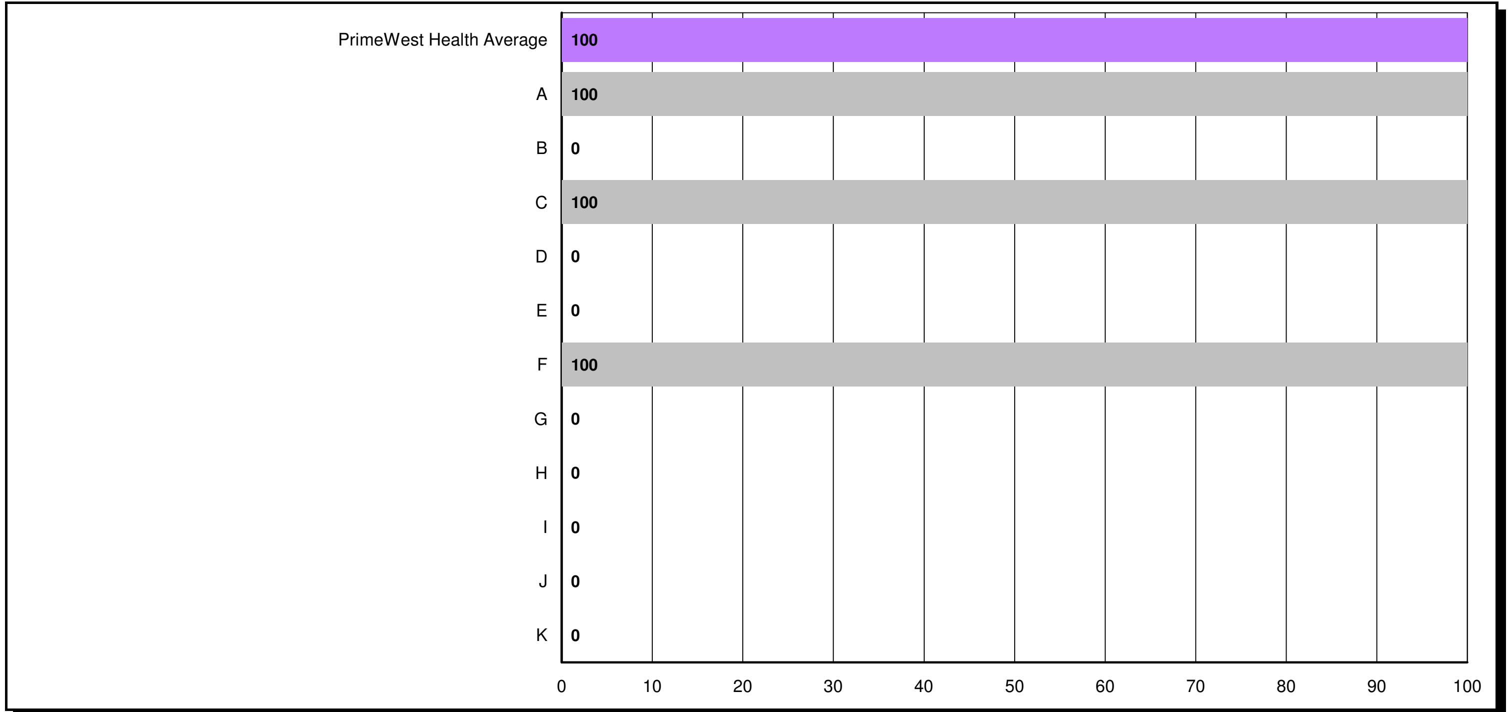
All reports of consultations or laboratory and imaging studies ordered are filed in the treatment record and are initialed by the practitioner who ordered them to signify review; or, another system of ensuring practitioner review is in place.

8. Clinically significant consultation, abnormal lab and imaging reports have an explicit notation of follow-up plans.



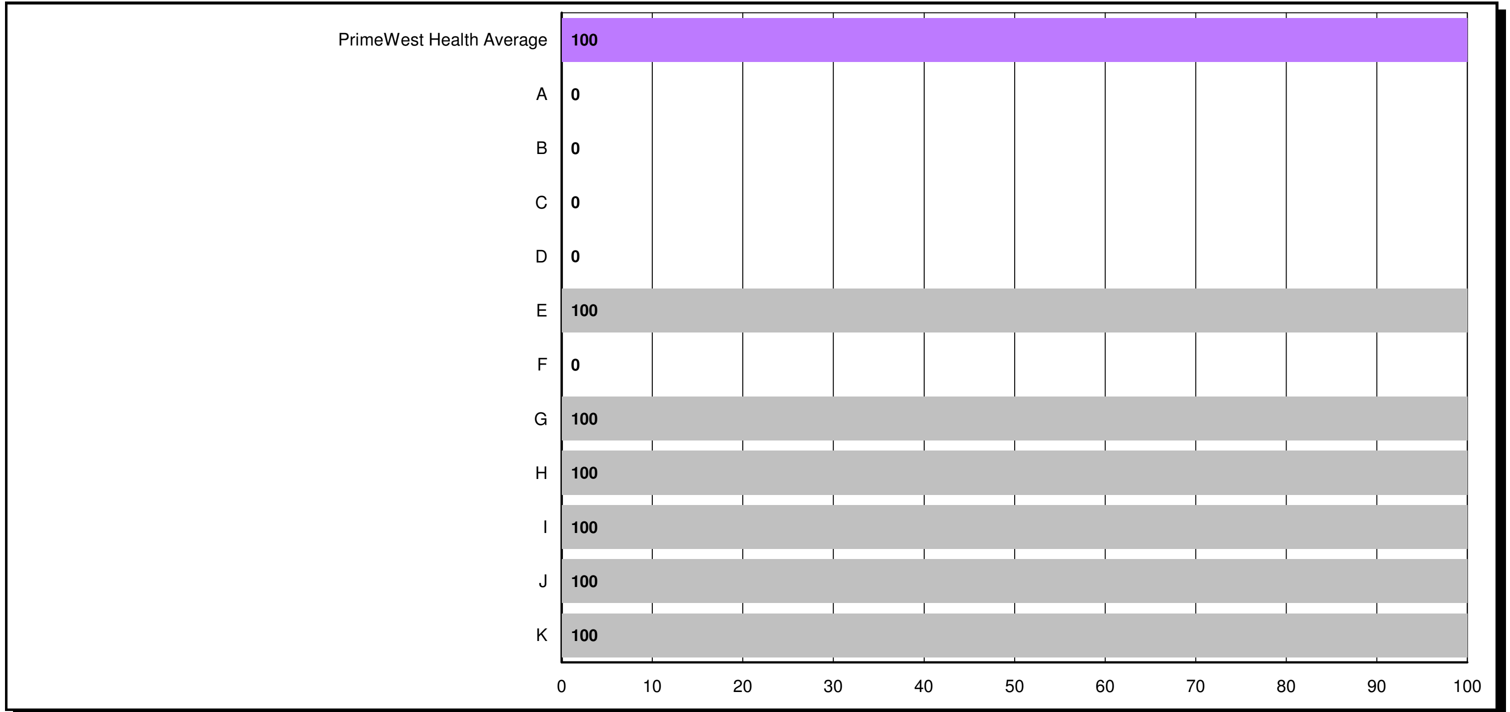
Follow-up care, communication of test results, and calls/visits are documented to indicate continuity of care. Subsequent visit notes and treatment plans reflect results of the reports as may be pertinent to ongoing care.

9. Discharge summaries are filed in the member's record.



Discharge summaries for diagnostic and therapeutic services for which a member was referred, such as hospital discharge reports, specialty physician reports, and home health nursing reports, are found in member's record when applicable.

10. At the closing of the case, a statement of the reason for termination, current client condition, and the treatment outcome are documented.



A statement of the reason for termination, current client conditions, and treatment outcome is documented at the closing of the case.