April-22

Optum - Behavioral Network Services

Community Crisis Center Treatment Record Review

Facility Name:

Reviewer Name:

Member Gender:

Member Age:

Diagnosis:

Date of Review:

	Rating Scale: NA = Not Applicable Y = Yes N = No	Y	N	NA
Assessment				
1	Each member has a separate record.			
2	The record includes the member's full name, address/living situation, employer or school, home and work telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
3	All entries in the record include the responsible service provider's name, professional degree and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.			
4	A DSM-V primary treatment diagnosis is in the record, and any secondary or co-occurring diagnosis, as appropriate.			
5	The record includes an eligibility assessment completed by a licensed staff within 30 minutes of the application of services. The eligibility assessment determines whether the member is in behavioral health crisis and whether or not they require inpatient or emergency room services.			
6	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.			

7	The record includes a medical assessment completed by a licensed medical staff. The medical assessment shall further evaluate the client for immediate medical needs **and necessity for referral**. The medical assessment shall also determine current medical needs and provide a health history.			
8	There is evidence of a complete risk assessment in the record, completed by a licensed professional.			
9	The presenting problem and conditions are documented.			
10	There is evidence of a substance use screening in the record which includes any history of substance use.			
11	There is evidence of treatment recommendations in the record that are based on the assessment.			
Plan of Care				
12	There is evidence the behavioral health assessments were used to develop the plan of care.			
13	There is evidence the plan of care is individualized.			
14	There is evidence the plan of care is person-centered.			
15	There is evidence the plan of care is strengths-based.			

16	There is evidence the plan of care was developed in a collaborative way.			
17	There is evidence the plan of care is family and community-focused.			
18	Cultural needs of the member have been addressed, documented, and incorporated into the plan of care.			
19	When appropriate, the plan of care indicates the family's involvement, or other natural support systems, in the establishing goals/objectives.			
20	Plan of care goals are outcome based.			
Interventions				
21	There is evidence of **appropriate acute stabilization related to psychiatric and substance use symptoms.**			
22	Interventions include individualized motivational strategies to help members who have made no commitment to change.			
23	Interventions include active treatment for individuals who need to learn and practice skills to manage their substance and mental health symptoms.			
24	Interventions include specific skills training and participation in self-help recovery programs, as well as specialized self-help programs like Dual Recovery Anonymous.			

25	Interventions include developing new skills and capabilities based on strengths, as well as developing improved self-esteem, pride, dignity, and sense of purpose in the context of the continued presence of mental health and substance use disorders.			
26	Interventions are delivered in the least restrictive manner and shall not utilize seclusion or restraints as part of its intervention services.			
27	In circumstances where an individual requires a more restrictive setting, then arrangements will be made to assist the individual to move to a more restrictive setting.			
Aftercare Planning				
28	There is evidence the facility makes referrals based on identified functional areas of impairment (medical, vocational, financial, housing, family, social activities of daily living, transportation, legal, and substance use).			
29	There is evidence of a written aftercare plan prior to discharging from the facility. The aftercare plan shall include, at a minimum, connection to a peer or Recovery Support Specialist.			