

Comprehensive Behavioral Health Management Clinical Chart Audit

Patient Initials & SSN											
1=MD or DO or NP, 2=PhD, 3=MFT, 4=LCSW, 5=LPC											
<b>ADMINISTRATIVE DATA (weight = 15)</b>	<b>1.0</b>	<b>2.0</b>	<b>3.0</b>	<b>4.0</b>	<b>5.0</b>	<b>6.0</b>	<b>7.0</b>	<b>8.0</b>	<b>9.0</b>	<b>10.0</b>	
All pages contain patient's name or ID#											
Patient Address											
Telephone Numbers (home and work)											
Employer or school											
Marital Status (Parent or guardian info for minors)											
Emergency contact											
Appropriate consent Form(s); Release of Information to abide by Federal Confidentiality Guidelines; Consent for Tx of minor											
Office Policies (e.g., N/S, Late Cancel, Emergencies) Acknowledged By Patient											
Review of Patient Rights documented											
All entries include treating clinician's name and professional degree											
Entries are timely and dated											
Record is organized, legible, & forms secured											
<b>SECTION SCORE</b>											
<b>MEDICAL AND PSYCHIATRIC HISTORY (weight=25)</b>											
Relevant medical conditions & current providers are listed, identified and significant changes are noted											
Past treatment: Dates, provider identification, type of therapeutic interventions, and responses											
Allergies and adverse reactions noted: lack of know allergies and sensitivities to pharmaceuticals or other substances is noted											
For children and adolescents, prenatal and perinatal events and developmental history											
For patients 12 and older, past and present use of cigarettes, alcohol and illicit, prescription, and over-the-counter drugs											
Relevant family history											
Record includes laboratory test results and consultation reports (as appropriate)											
<b>SECTION SCORE</b>											
<b>CLINICAL DATA - ASSESSMENT (weight=30)</b>											
Identified problem and history of presenting problem											
Mental Status Exam includes affect, speech, mood, thought content, judgment, insight, attention/concentration, memory and impulse control											
All risk factors (SI, H/I, CD, History of non-compliance) noted with appropriate intervention											
Psychosocial History (includes current living situation, support systems, legal issues)											
<b>SECTION SCORE</b>											

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<b>CLINICAL DATA - TREATMENT (weight=30)</b>										
DSM IV Diagnoses Axis 1-V										
Diagnosis is consistent with assessment										
For minors, assessment documents need for family therapy										
Subsequent session progress notes are consistent with diagnosis										
Treatment plan consistent with diagnosis										
Treatment plan includes measurable goals										
Treatment plan includes estimated time frames for goal attainment or problem resolution										
Review of treatment plan documented										
Progress notes describe patient's strengths and limitations in achieving treatment goals and objectives; summary of progress; interventions and assessment of response										
Patient's understanding of the treatment plan is noted										
Record indicates what psychotropic medications have been prescribed.										
Dosages noted by MD (N/A for non-MD)										
Length of time on medication (MD notes reflect dates)										
MD notes reflect date of initial prescription										
MD record reflects informed consent for medication										
Risk factor updates noted and referred to the appropriate level of care										
Documentation of preventative services (including use of homework assignments) and referrals to community resources										
HIPAA release of information signed & included for each contact person										
Record reflects continuity of care between all mental health providers (HCCF faxed or mailed)										
Record reflects coordination of care with medical providers. (HCCF faxed or mailed) Patient refusal documented										
Documentation of dates of follow-up appointments, or, as appropriate, a discharge summary										
<b>Quality of Care issues</b>										
<b>Referral to Committee for Review</b>										
<b>SECTION SCORE</b>										
Score per case										