LRE SUD Clinical Chart Review Tool FY22

#	Standard/Elements	Source/Basis	Evidence May Include	Review Guidelines
SUD Intake/Assessment				
1.1	At point of initial contact, provider collected the following: • Date of initial contact, Follow-up Communication(s) • Presenting Issue • Priority Population Status • Eligibility Determination • ASAM Level of Care Determination	PIHP Contract; Access System Standards	Consumer Chart Brief Screening and Level of Care Determination	Date of First Request is accurate according to when client called for service NOT the date client was admitted.
1.2	Provider obtains the following information: • Medical Information including o Primary Care Provider Name, Address, Telephone o Date of Last Physical o Relevant Medical Information • Mental Health background & present issues • SUD History – Use & Treatment • Legal background and present issues • Emergency Contact • Financial Information (Block Grant Only)	PIHP Contract; Access System Standards MDHHS Requirements LARA Regulations	Consumer Chart. PCP Release of Information Assessments *Name, Address Telephone – Provider documentation of specifics may not be implemented until after review. May be found via fax/releases.	*Legal background and present issues *Make a referral and document referral for clients who do not have a PCP or other needed services (mental health, dental, etc.) *If last physical was not in the past year, make a recommendation or referral for that consumer. **PCP needs may be something to add to treatment plans *Block Grant Financial Eligibility Form is complete, and a copy saved in client chart if client is using BG funding
1.3	The Release of information for PCP is signed and in their record. If there is not a signed release in the chart: There is documentation that the consumer declined.			
1.4	There is evidence of screening for: • HIV/AIDS, STD/Is, TB, Hepatitis • Trauma		Provider Intake/Assessment Forms	Provider is utilizing additional screening tools for communicable disease and trauma OR these items are embedded in assessment. Clinical documentation should indicate what follow-up is recommended (and occurs) as a result of positive screening

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1.5	Evidence consumer has received information regarding: • General nature and objectives of the program • Notice of Privacy • Consent to Treatment • Advanced Directives • Member Handbook • SUD Recipient Rights • Grievance and appeal • Informal Conflict Resolution	R 325.14701; 701 (6) (a)(c) (d R 325.14305(3) 42 CFR § 438(g)(1); 42 CFR 438.6 Admin. Rule R325.1397(4)(a-f)	Consumer chart Recipient Rights understanding form (required) Handbook receipt/offer form (chart note)	
1.6	FASD The following circumstances should prompt a clinician to complete a screen to determine if there is a need for a diagnostic referral: When prenatal alcohol exposure is known and other FAS characteristics are present, a child should be referred for a full FASD evaluation when substantial prenatal alcohol use by the mother (i.e., seven or more drinks per week, three or more drinks on multiple occasions, or both) has been confirmed. When substantial prenatal alcohol exposure is known, in the absence of any other positive criteria (i.e., small size, facial abnormalities, or central nervous system problems), the client will be referred to the primary care physician for further assessment. When information regarding prenatal exposure is unknown, a child should be referred for a full FASD evaluation.	MDHHS Treatment Policy 11	Consumer Chart Intake Packet/Forms Individual/Group Progress Note Assessment	Note for reviewer: Standard applies to all individuals (men/women) who have care of a minor child. Standard is not specific to only women with minor children.

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1.7	Initial assessment and/or timely reassessment contains required elements: • ASAM Level of Care-Determination is justified and meets the needs of consumer. • Provisional DSM Diagnosis • Clinical Summary • Recommendations for Care	BSAAS Policy #09, Outpatient Treatment Continuum of Services Access System Standards PIHP Contract	Consumer Chart	Re-assessment should be completed annually
1.8	List Date of Assessment			
SUD Individual Treatment/Recovery Planning and Documentation				
2.0A	List Date of treatment plan:			
2.0B	The timeframe between the initial assessment and the IPOS was in acceptable limits (for new intakes only).			
2.1	The amount, scope, and duration are identified in the treatment/recovery plan and appropriate for consumer's identified goals and objectives.	BSAAS Policy #6 p.4 Medicaid Manual	Treatment plan & Authorization(s)	Amount, scope and duration should align with what is being requested in authorizations.
2.2	Initial treatment plan is developed before consumer is engaged in extensive therapeutic activities: • Outpatient – during/before 3rd session • Residential – within 72-hours of admission • Detoxification – within 72-hours of admission		Initial Treatment Plan with Date & Signatures _ Corresponding Progress Note(s)	
2.3	Plan(s) address needs/issues identified in assessment(s) (or clear documentation of why issue is not being addressed) including but not limited to: • Substance Use Disorder(s) • Medical/Physical Wellness • Co-Occurring D/O • History/Risk/Present Trauma • Gambling	BSAAS Policy #6 p.2, #1;	Treatment plan Assessment Needs Assessment Screen(s) – Trauma, Co-Occurring (did results indicate a need for action on a treatment plan)	

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2.4	Treatment/Recovery Plan is individualized and includes the following: 1. Goals are expressed in the client's words and are unique to the client- No standard or routine goals that are used by all clients. 2. Intervention strategies – the specific types of strategies that will be used in treatment – group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc. 3. Signatures – client, counselor, and involved individuals, or documentation as to why no signature.	BSAAS Policy 06	Treatment plan	• Treatment plans should cover all dates of services being requested. • Goals & Objectives should not have all the same target & completion dates.
2.5	Goals and objectives are written using SMART criteria. (S-Specific, M- Measurable, A- Attainable, R-Relevant, T-Time bound)	Treatment Policy #06, Individualized Treatment Planning Treatment Plan	Treatment Plan	
2.6	Frequency of periodic reviews of the plan are based on the time fre in treatment and any adjustments to the plan. •	BSAAS Policy 06	Treatment plan reflects timely review.	
2.7	The treatment and recovery plan progress review to check for: 1. Progress note information matching what is in review. 2. Rationale for continuation/discontinuation of goals/objectives. 3. New goals and objectives developed with client input. 4. Client participation/feedback present in the review. 5. Signatures, i.e., client, counselor, and involved individuals, or documentation as to why no signature	BSAAS Policy 06, p 5.	Treatment plan(s) & reviews include consumer signature with date, consumer feedback (specifically the reviews), etc.	

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2.8	An evidence-based practice was used and documented in the record for trauma.	MDHHS Recovery Policy Practice TA-T-12	Assessment Progress notes Other documentation in the record Screening tools	Only include evidence-based practices for trauma. Other EBPs are included in a separate standard. Please identify the evidence-based practice in the comment box that was used in the record. Mark yes if an evidence-based practice was present. Mark no if there was not an evidence-based practice in the record.
2.9	An evidence-based practice was used and documented in the record.	MDHHS Recovery Policy Practice TA-T-12	Assessment Progress notes Other documentation in the record Screening tools	Do not include evidence-based practices for trauma as it is included in a separate standard. Please identify the evidence-based practice in the comment box that was used in the record. Mark yes if an evidence-based practice was present. Mark no if there was not an evidence-based practice in the record.
SUD Record Documentation and Progress Notes.				
3.1	Progress notes reflect information in treatment plan(s): • Identify what goal/objective(s) were addressed during a treatment session • Individual and group sessions that the person participates in must address or be related to the goals and objectives in the plan Document progress/lack of progress toward meeting goals. • Evidence of Recovery planning activities are taking place during the treatment episode.	BSAAS Treatment Policy #06	Documented progress notes reflect relationship to goals and objectives in the treatment plan.	For occasions in which goals were not addressed i.e. crisis), document reason.
3.2	Services are provided as specified in the plan(s).	MPM	Progress notes demonstrate the services are provided, as indicated on the consumer's Individual plan of service.	Notes are reflective of authorized services and match plan. No shows and cancellations are documented.

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3.3	Consumer strengths are identified within the record and used to drive the person-centered planning process	BSAAS Policy #06.	Assessment and treatment plan.	Combined standards 1.5 and 2.3 into 1 standard and moved to Documentation section.
Coordination of Care				
4.1	There is evidence of primary care physician coordination of care efforts.	PIHP Contract;	Consumer file, documented communication/coordination	Was there any coordination of care; not just getting a consent form. Could be done through a letter being sent/faxed alerting PCP a consumer is on the medication you're prescribing. If not PCP, tracking the referral, following up and noting the outcome of referral.
4.2	There is evidence of coordination of care with external entities including, but not limited to, legal system, child welfare system, behavioral healthcare system.	PIHP Contract; R 325.14704	Consumer file	Ensure you are documenting coordination of care efforts. This should include phone calls, emails, meetings, etc. There should be coordination with all relevant parties as is needed for support of consumer's treatment/ engagement/recovery.
4.3	There is evidence of effective coordination between transitions from one provider or level of care to another. Evidence may include sharing of assessments, treatment plans, and discharge information that improves care and reduces redundancy for the person served.	SAPT MAT Consensus Statement	Consumer file	Required for consumers entering services from another provider or level of care. Providers should send/request assessments, discharge(s), treatment plans and any other documents relevant to care that would reduce redundant work.
4.4	There is evidence that provider makes appropriate referrals and documents follow-up and outcomes, as is applicable to meet the consumer/family needs.	LARA SUD Administrative Rules, R 325.1359 R325.1363	Consumer Chart	When needs are identified there should be services provided to meet the needs. If the provider does not offer the services, a referral to an agency that offers the services should be made.

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SUD Discharge/Continuity in Care				
5.1	Discharge Summary includes all Continuum of Care Detail(s) including next provider contact information, date/time of intake appointment, relevant information etc.		Discharge Summary	
5.2	Consumer's treatment episode is summarized including: • Status at time of d/c (Status may include prognosis, stage of change, met & unmet needs/goals/objectives, referrals &/or follow-up information) • Summary of received services/ participation • Discharge rationale is clearly & accurately documented	MDHHS-MH/SA R325.14909 & R325.14928	Consumer file includes discharge summary with required status and condition described. Discharge summary clearly indicates rationale.	

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SUD Residential				
6.1	Residential detoxification: At the time of admission and prior to any medications being prescribed or services offered, the medical director, a physician, physician's assistant, or advanced practice registered nurse will complete and document the medical and drug history, as well as a physical examination. Residential: The recipient record for residential service categories shall also include medical history and physical examination	R 325.1387 R 325.1361 R 325.1361	Copy of medical exam is included in the client chart.	Verify the date of medical history and examination are prior to the first date of medication being dispensed for new medications. Withdrawal Management- Verify date of medical history and examination are prior to services being provided. Physical exams should be in 24 hours
6.2	Residential Treatment PROVIDER must assure all consumers entering residential treatment will be tested for TB upon admission and the test result is known within five (5) days of admission	Prevention Policy #02	Copy of TB testing & results is included in the client chart.	Verify TB test is included in the record.
6.3	Chart reflects services provided in accordance with the ASAM LOC Determination. • 3.1 = 5 hours Core Services & 5 hours Life Skills/week • 3.3= 13 hours Core Services & 13 hours Life Skills/week • 3.5 & 3.7 = 20 hours Core Services & 20 hours Life Skills/week	BSAAS Policy #10	Clinical documentation in client's chart	Residential Service Description's as described in BSAAS Policy #10 are used to determine hours. Determination of hours are based on documentation in the record and not from a schedule. In situations where the required services cannot be provided to a person in the appropriate frequency or quantity, a justification must be documented in the person's record.

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SUD Medication Assisted Treatment (MAT)				
7.1	Documentation that a medical evaluation, including a medical history and physical examination, has been performed before the patient receives the initial methadone or Suboxone dose. (However, in an emergency situation the initial dose of methadone may be given before the physical examination).	Admin. Rule R325.14404	Copy of medical exam is included in the client's chart.	Include Vivitrol. Copies of med exam in record. Hold – what must be included TX History Meds IV Use Pregnancy/Child Bearing Age STI's
7.2	Informed consent for pregnant women and all women admitted to methadone or Suboxone assisted treatment that may become pregnant, stating they would not knowingly put themselves and their fetus in jeopardy by leaving treatment against medical advice.	MDHHS Policy #05, page 6 of 11, 10/1/12	Signed Consent Form	
7.3	Documented random toxicology testing. SUBOXONE ONLY: toxicology screens must be done at intake and then randomly, at least weekly, until 3 consecutive screens are negative. Methadone ONLY: consumer screened weekly. Monthly only occurs after 6-months of consecutive negative screens. Any positive screen results in new 6-month cycle of weekly screens.	R325.14406	Clinical documentation in client's chart	This aligns w/ updated LARA rules. THC w/o med mj card is considered illicit use of substance.
7.4	Copies of the prescription label, pharmacy receipt, or pharmacy print out, must be included in the individual's chart or kept in a "prescribed medication log" that must be easily accessible for review.	BSAAS Treatment Policy #05	Clinical documentation in client's chart	MAPS conducted at intake. Look for counter-reactive meds. Phase change also should result in MAPs. Physical – include MAPs. Be aware of over-the-counter meds and document in case of disputed test results (meds causing false negatives can be easily checked sometimes)

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7.5	Documented review of Michigan Automated Prescription System (MAPS) is included in the client file at admission, a prior to any off-site dosing, and prior to any reauthorization requests. Note: Per MDHHS guidance, the MAPS report cannot be placed in the individual's chart. Information can be documented in the chart.	MDHHS Policy #05, page 5 of 11, 10/1/12	Clinical documentation in client's chart	Documentation of MAPS report outcomes in chart.
7.6	If applicable, for enrolled individuals there must be a copy of the MDHHS registration card for Medical Marijuana issued in the individual's name in the chart. Provider Note: Behavioral Health symptoms, related to the issuance of a medical marijuana card are identified in assessment/progress note, and addressed within the treatment plan.	MDHHS Policy #05	Clinical Documentation in client's chart	If there are symptoms or a diagnosis related to the prescription of medical marijuana, is this addressed on the plan; assessment; etc.
7.7	Documentation that there is coordination of care with prescribing physician when there are prescriptions for controlled substances.	MDHHS Medication Assisted Treatment Guidelines for Opioid Use Disorders	Signed release of information, clinical and medical documentation in client's chart.	Get the release, call the doctor, send mutual patient letter, etc. Very important for Benzo's etc. Be cautious of counter-reactive substances
7.8	All alcohol use and illicit drug use during treatment is addressed in treatment and documented in Progress Notes.	BSAAS Treatment Policy #05, p. 7	Clinical documentation in client's chart. Drug screen outcomes, indicating illicit use, are addressed immediately and communication is documented.	

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7.9	**METHADONE ONLY:** Documentation that the client has been continuously physiologically **addicted to a narcotic for at least 1 year** before admission to a program.	R325.14409(1).	Clinical documentation in client's chart	May see info via physical. Must have DSM V Documentation.
7.10	**METHADONE ONLY:** Documentation that the physical examination includes medical assessment to confirm the current DSM Diagnosis of Opioid **dependency of at least one year** as was identified during screening process	MDHHS/CA Contract Treatment Policy #05	Clinical documentation in client's chart	
7.11	**METHADONE ONLY:** Documentation that the OTP, as part of the informed consent process, has ensured that individuals are aware of the benefits and hazards of methadone treatment.	BSAAS Treatment Policy #05, 10/1/12, p. 4 of 11.	Clinical documentation in client's chart	Should be signed and in consumer record. Generally found as part of the intake paperwork. Checklist w/ initials also acceptable.
7.12	**METHADONE ONLY:** Documentation that the client is informed of emergency procedures to be followed when there is an adverse reaction, overdose, or withdrawal. (Client is given emergency numbers to contact in case of emergency with medications that occur outside regular business hours).	R 325.14422	Clinical documentation in client's chart	Verified via checklist/signed acknowledgement. Should complete during intake.
7.13	**METHADONE ONLY:** Evidence that daily attendance at the clinic is occurring for methadone dosing, including Sundays and holidays if criteria for take home medication are not met.	BSAAS Treatment Policy #05.	Clinical documentation in client's chart	Clinical documentation – included in record. EMR can generally track dosing info. Consumers sign for dosing, etc. Records should flag consumer's meeting take home criteria requirements.
7.14	For clients who enter MAT programs and/or are being discharged from MAT, are they provided with naloxone opiate overdose reversal kits?	MDHHS Medication Assisted Treatment Guidelines for Opioid Use Disorders		